

2013

Ontario Automobile Insurance Dispute Resolution System Review

Interim Report

October 2013

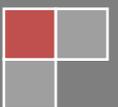


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ONTARIO AUTOMOBILE INSURANCE DISPUTE RESOLUTION SYSTEM REVIEW

INTERIM REPORT

Introduction

Demand for dispute resolution services by Ontario auto insurance claimants has risen dramatically in the past few years, creating a backlog of cases awaiting mediation at the Financial Services Commission of Ontario (FSCO). The backlog has been addressed for the time being through a combination of productivity improvements and additional resources. However, the high number of disputes in the Ontario auto insurance system suggests that there are systemic problems that need to be addressed.

A review of the Ontario auto insurance dispute resolution system (DRS) was announced in the 2012 Ontario Budget. The 2013 Ontario Budget committed to the appointment of an expert to review the system and propose legislative amendments in the fall of 2013.

On August 23, 2013, I was appointed by the Ontario Minister of Finance, the Honourable Charles Sousa, to conduct a review of Ontario's DRS. I have been assigned two tasks:

- Deliver an interim report this fall that considers 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.
- Deliver a final report by February 2014, that provides 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.

In conducting this review, I am capably assisted by Mr. Murray Segal, a former Deputy Attorney General of Ontario, and Mr. Willie Handler, an authority on the auto insurance system in Ontario. In addition, I am most appreciative of the support provided by staff from the Ministry of Finance and FSCO in supplying me with DRS statistics and earlier DRS studies, setting up informal stakeholder meetings and consultations and reviewing submissions from various stakeholders.

This interim report provides an overview of the history and structure of the Ontario auto insurance DRS, the structure of auto insurance dispute resolution systems across Canada and in other jurisdictions and trends in the current Ontario DRS, including outcomes of recent court and arbitration decisions. While I have arrived at some tentative views, I am hopeful this interim report will permit participants and stakeholders to comment further as I prepare my final report.

As requested, I will be submitting my final report by February 2014 with final recommendations.

History and Overview of Dispute Resolution at FSCO

Financial Services Commission of Ontario

The Financial Services Commission of Ontario (FSCO) is a regulatory agency of the Ministry of Finance that regulates insurance, pension plans, loan and trust companies, credit unions, caisses populaires, mortgage brokering, and co-operative corporations in Ontario. FSCO was established on June 30, 1998 with the enactment of *the Financial Services Commission of Ontario Act, 1997*. The Act merged the Ontario Insurance Commission, the Pension Commission of Ontario and the Deposit Institutions Division of the Ministry of Finance into a single body.

The Superintendent of Financial Services administers and enforces the *Financial Services Commission of Ontario Act, 1997* and all other Acts that confer powers on or assign duties to the Superintendent. The Superintendent also exercises the powers and duties conferred upon the Superintendent by these Acts. All FSCO staff report directly or indirectly to the Superintendent. FSCO staff, who are public servants under the *Public Service of Ontario Act, 2006* perform FSCO's day-to-day work.

Auto insurance in Ontario is a significant part of the property and casualty insurance market. There are more than nine million drivers in the province with more than six and a half million insured vehicles. Private passenger auto insurance comprises 87 per cent of the auto insurance market; the balance is comprised of other lines of vehicle insurance, including both commercial and fleet insurance. Auto insurance is delivered privately in Ontario by more than 100 companies.

As auto insurance is a mandatory product in Ontario, a comprehensive regulatory system has developed. The system includes the setting of mandatory and optional levels of coverage, as well as a rate approval system, a dispute resolution system for no-fault claims and market conduct regulations. Auto insurance can be considered as a "closed loop" system, as costs and expenses are recovered through premiums charged to consumers. Higher costs translate into higher premiums.

Auto insurance is a complex product that has undergone a number of reforms over the past 23 years. The focus of previous reforms has been on the balance between price and appropriate coverage, as well as between third party liability coverage (tort) and statutory accident benefits (no-fault). The majority of the reforms were initially successful in stabilizing costs and premiums, only to be followed by cycles of rising costs as new practices developed that neutralized the impact of reforms.

History of Auto Insurance in Ontario

Prior to June 1990, auto insurance in Ontario largely operated under the tort system. This meant people who were injured in auto accidents received minimal accident benefits from their own insurer (e.g., a maximum \$140 per week to replace lost income), and claimed unreimbursed expenses (special damages), such as lost wages or medical expenses as well as compensation for pain and suffering (general damages), from the at-fault party. The majority of accident victims were represented by lawyers and, if a settlement could not be reached, the claimant's only option was to sue the at-fault driver.

Mr. Justice Coulter Osborne was appointed in November 1986 to report on the tort system of compensation for injury by auto accident and the consequences of the implementation of a no-fault auto accident insurance scheme. Mr. Justice Osborne was also to examine the merits of public versus private automobile insurance delivery systems.

The Report of Inquiry into Motor Vehicle Accident Compensation in Ontario by Mr. Justice Osborne was delivered to the Legislature in April of 1988. It identified rapidly increasing loss costs for third party liability bodily injury claims (tort claims) in the early 1980s without offsetting premium increases as the basis for the auto insurance "crisis."

The Ontario auto insurance system underwent a major change on June 1, 1990, when the *Insurance Statute Law Amendment Act, 1990* (also known as Bill 68 or the Ontario Motorist Protection Plan [OMPP]) came into effect. It was referred to as a "threshold no-fault system" because the ability to sue was restricted to those with permanent serious physical impairments.

In addition to introducing no-fault insurance in Ontario, the statutory changes established: the Ontario Insurance Commission (OIC); mediation and arbitration to resolve disputes regarding accident benefit compensation; a first-party payer system (where you claimed compensation from your own insurer instead of suing the at-fault driver) for statutory accident benefits and property damage claims; and a system for rate approvals administered by the OIC. This represented a fundamental shift from a tort-based system to one based on no-fault accident benefits. The right to sue for both economic loss and pain and suffering was restricted to cases that met a verbal threshold (i.e., a permanent serious physical impairment). The changes were introduced in part to respond to the escalating costs and delays inherent in tort claims.

Following an initial effort to introduce a public auto insurance system in Ontario, the government in 1994 reformed the compensation framework with the introduction of Bill 164, an *Act to Amend the Insurance Act, S.O. 1993*. Bill 164 eliminated the right to sue for economic damages and expanded the right to sue for pain and suffering to cases of serious physical, mental or psychological injuries.

At the same time, Bill 164 included a significant expansion in the level of and access to statutory accident benefits, which were also subject to indexation. Bill 164 also created an additional mechanism to resolve medical disputes prior to mediation by introducing neutral medical assessments through Designated Assessment Centres (DACs).

In 1996, the government restored the right to sue for economic loss with the introduction of Bill 59, the *Automobile Insurance Rate Stability Act, 1996*. However, at the same time, the ability to sue for pain and suffering was limited by a \$15,000 deductible in addition to a verbal threshold for serious and permanent impairment. To offset the expansion of tort, the level of statutory accident benefits was reduced. However, a higher tier of medical, rehabilitation and other benefits was maintained for catastrophic injuries. At that time, other changes were introduced to control costs, including the prior approval of treatment and the ability for the Superintendent to issue fee schedules for health care provider services.

In another effort to control rising costs, the government introduced further reforms in 2003 with the *Keeping the Promise for a Strong Economy Act (Budget Measures), 2002*, also known as Bill 198. The Bill provided a pre-approved framework for the treatment of whiplash injuries, reduced the maximum hourly fees for health care providers, increased the deductible for pain and suffering awards to \$30,000 and expanded the right to sue for excess health care expenses (i.e., in excess of the *Statutory Accident Benefits Schedule* [SABS] limits).

Claimants and insurers were prohibited from settling statutory accident benefit claims until the one-year anniversary of the accident. A code of conduct was created for paralegals and they were required to file information with the Superintendent if they were to continue handling accident benefit claims.

In 2005, the government introduced reforms that eliminated the DACs, expanded the role of insurer examinations and allowed claimants to undergo an additional round of assessments (referred to by stakeholders as “rebuttal assessments”).

Paralegal regulation was assumed by the Law Society of Upper Canada in 2007.

September 2010 Reforms

In spite of all the changes over the years, costs continued to increase. In particular, the period between 2006 and 2010 was marked by a rapid rise in accident benefits claims and costs, mainly in the Greater Toronto Area (GTA).¹ Because insurance is a closed loop system, premiums for consumers increased.

During the same 2006-2010 period, the number of accidents and injuries reported to the police decreased, while the number of accident benefit claims increased. In other words, there were fewer accidents and injuries but more claims. This trend was not consistent with the experience in other provinces.² During the 2006-2010 period, accident benefit claims costs in Ontario increased by more than 100 per cent. Some of the more significant increases were as follows:

- Housekeeping expenses increased by 178 per cent
- Attendant care benefit costs increased by 67 per cent
- Caregiver benefit costs increased by 186 per cent
- Assessment and examination expenses increased by 228 per cent.

Also during this period, the cost of assessments and examinations rose to almost equal to the cost of medical and rehabilitation treatment. These increases occurred in a period during which:

- Personal injury collisions declined by 7.1 per cent
- The number of persons reported injured declined by 9.1 per cent.

In response to these issues and in an ongoing effort to control costs and to reduce premiums, the government introduced substantial changes to the SABS in September 2010. The new SABS had lower mandatory statutory accident benefits but provided consumers with the ability to “buy up” to previous levels. However, very few consumers are actually purchasing optional accident benefits.

¹ The GTA includes Durham, Halton, Peel, Toronto and York Regions

² From Ontario Private Passenger Automobile Actual Loss Ratio Exhibits published by the General Insurance Statistical Agency.

FSCO's Dispute Resolution System (DRS)

In spite of the many changes over the years to the SABS, the DRS has undergone very few changes since its introduction in 1990. The most significant change took place in 1996 when Bill 59 introduced an additional step prior to arbitration: neutral evaluation. In neutral evaluation, an experienced evaluator assesses the issues in dispute and gives a non-binding opinion about the likely outcome of the case if it goes to arbitration or to court.

FSCO's DRS was established in 1990 as a cost effective and timely alternative to the courts. FSCO's Dispute Resolution Services Branch³ (DRSB) has a mandate to ensure a fair, accessible and timely process for resolving disputes in respect of a person's entitlement to statutory accident benefits or the amount of those benefits under the SABS.

Although either party — claimant or insurance company — may apply for mediation, FSCO's statistics show close to 100 per cent of Applications for Mediation are filed by or on behalf of claimants. If there are any issues remaining in dispute following mediation, the claimant may apply for arbitration at FSCO, proceed to court or, with the agreement of the insurer, turn to private mediation, arbitration or neutral evaluation. In addition to mediation and arbitration services, FSCO also offers neutral evaluation, appeal of arbitration orders on a point of law, and variation or revocation of an arbitration order under a defined set of circumstances.

There is no immediate correlation between the date of an auto accident and the date a claimant applies for mediation. An insurer may pay a claim for many years before denying further benefits, and it would be at that point an Application for Mediation might be filed. As a result, FSCO continues to receive Applications for Mediation in which the accident occurred many years before. Insurance companies are often not aware there is a dispute until advised by FSCO because there is no requirement that claimants inform their insurer that an Application for Mediation has been filed.

³ The Dispute Resolution Services Branch is part of FSCO's Automobile Insurance Division. The DRSB is comprised of three key areas: Mediation Services, Arbitration Services and Appeals.

Although the DRS was originally envisaged to be one in which legal representation was not required, it quickly became the norm. FSCO's records show that, in mediation, 98 per cent of claimants and six per cent of insurers retain counsel.⁴ In arbitration, 99 per cent of claimants and 100 per cent of insurers have legal representation. Increased use of legal representation has changed the nature of FSCO's DRS and contributed to delays in scheduling proceedings, particularly in arbitration. Lawyers' and paralegals' calendars are often fully booked many months in advance, and parties are frequently requesting dates for pre-hearings and hearings more than a year into the future.

Beginning in 2007, FSCO began to experience a dramatic increase in Applications for Mediation. In 2006–07, FSCO received 13,053 new applications and in 2011–12, received 35,727 applications — a 174 per cent increase. As a result, FSCO was not able to meet the legislated 60-day timeline for mediation and a backlog⁵ of files awaiting assignment to a mediator developed. At the end of December 2011, there was a backlog of approximately 30,700 files, FSCO was receiving an average of 2,949 new Applications for Mediation every month and claimants were waiting in excess of 11 months for mediation.

FSCO had long interpreted the requirement that mediation be concluded within 60 days of a file being assigned to a mediator (unless the parties agreed to an extension) as meaning that the 60 days began once a file was assigned to a mediator. In 2012, this interpretation was challenged both at FSCO Arbitration and in the courts. On November 29, 2012, the Ontario Court of Appeal issued a decision⁶ that upheld several lower court decisions.⁷ The Court of Appeal held that mediation is deemed to have failed if it does not occur within 60 days of the Application for Mediation being filed with FSCO, unless the parties consent to an extension.^{8 9}

⁴ Insurers are represented at mediation by internal ADR specialists.

⁵ The backlog is defined as files not assigned to a mediator.

⁶ *Hurst v. Aviva Insurance Company*, 2012 ONCA 837.

⁷ *Cornie v. Security National*, 2012 ONSC 905.

⁸ *Leone and State Farm Mutual Insurance Company*, FSCO A11-002196 (February 10, 2012).

⁹ It should be noted that an arbitration appeal decision on failed mediation came to a similar conclusion as the Court of Appeal.

In December 2011, the annual report of the Office of the Auditor General of Ontario (OAGO) recommended that FSCO:

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 [Statutory Accidents Benefits Schedule] benefits policies that can be changed or clarified to help prevent disputes (emphasis added)¹⁰

The OAGO 2011 report noted a dramatic increase in the demand for mediation services between 2006–07 and 2010–11 (i.e., 136 per cent increase in applications, 645 per cent increase in pending applications). OAGO further noted that approximately 80 per cent of mediation applications originated from the GTA.

As part of its response to OAGO, FSCO committed to:

*...look at additional data collection that might assist in identifying ways to reduce the high demand for dispute resolution services.*¹¹

FSCO undertook a number of initiatives in response to the backlog. This included settlement blitz days, consent to fail mediation forms, bulk file assignments to mediators and, most notably, the development of an electronic scheduling system known as the eCalendar. Previously, all mediations were scheduled manually by the assigned mediators. The eCalendar allows the parties to schedule the mediations themselves without the involvement of FSCO's mediators. As a result, efficiencies have increased and mediators are able to handle more files each week.

In addition to increased internal efficiencies, FSCO entered into an agreement with a private service provider (following an open RFP procurement process), ADR Chambers, to provide supplementary mediation and arbitration services. The contract with ADR Chambers was signed on August 17, 2012, specifying that FSCO would assign a maximum of 2,000 mediation files and 500 arbitration files per month. The contract with ADR Chambers has been instrumental in eliminating the backlog. ADR Chambers received its final allotment of mediation files on August 19, 2013, by which time the mediation backlog had been eliminated and has since been transformed into an arbitration backlog.

¹⁰ 2011 Annual Report of the Office of the Auditor General of Ontario, p. 62.

¹¹ 2011 Annual Report of the Office of the Auditor General of Ontario, p. 62.

Beginning in 2012, the volume of new Applications for Mediation began to decrease. In 2011–12, FSCO received 35,727 new applications. This fell to 25,309 in 2012–13. FSCO’s mediators are now able to remain current with the volume of new Applications for Mediation. This is not only due to the fact the mediators are handling more files per week, but more significantly due to the decrease in new applications. Although the volume of new applications has dropped overall, it has been increasing once again month-over-month since March 2013.

Not only has FSCO experienced a mediation backlog over the past several years, but there has been a steady increase in Applications for Arbitration since 2006–07. More recently, the increase in the volume of new Applications for Arbitration has been increasing, rapidly flowing from the reduction of the mediation backlog.

There are several reasons for the increase:

- Historically, 50 per cent of failed mediations had proceeded to arbitration at FSCO. Now, 72 per cent of failed mediations move on to arbitration.
- Due to the clearing of the mediation backlog and the increased efficiency of FSCO mediators, high volumes of mediation files are moving through the system much more quickly.
- Mediation settlement rates have dropped significantly. In the fourth quarter of 2012–13, the average settlement rate was 42 per cent, compared with an average settlement rate of 64 per cent in the fourth quarter of 2011–12.

These factors have combined to create a “perfect storm:” many more mediation files are moving through the system, fewer are being resolved, and a higher percentage of failed mediations are proceeding to arbitration.

Trends and Challenges

The nature and occurrence of disputes cannot be fully explained by examining caseload trends in the DRS. Disputes are potentially influenced by a large range of external factors, including: frequency and severity of accidents; dispute prevention and settlement strategies by insurers; fractious insurer-claimant-legal relationships; expectations/beliefs regarding access and entitlement to benefits; staged or fraudulent accident claims; and treatment practices by medical-rehabilitation service providers and clinics.

In 2012, FSCO began collecting information to help identify trends in behaviour of DRS participants and system design features that might be contributing to high numbers of applications, delays and low settlement rates. FSCO collected quantitative information from two main sources:

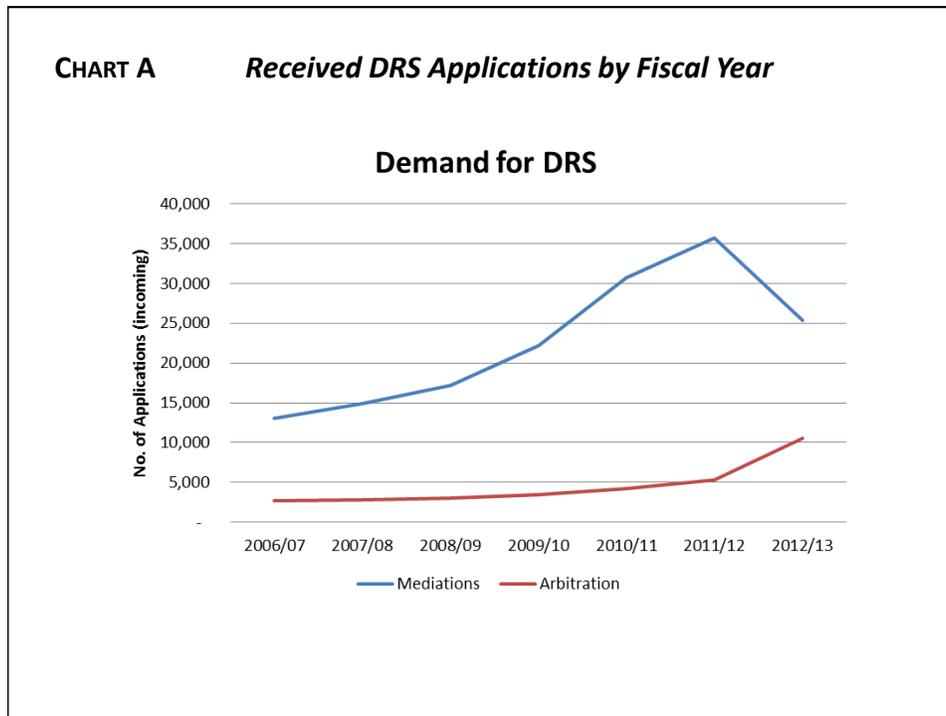
- An analysis of information collected via an internal DRS workflow database used to track mediations and arbitrations.
- An internal survey on 350 closed mediation files, randomly selected from a pool of files that were mediated by FSCO and with a date of loss on or after September 1, 2010.

Demand for DRS Services Remains High

Table 1 and Chart A below illustrate the demand for DRS services from 2006–07 to 2012–13. The demand for DRS services continues to be relatively high, although there had been a recent drop in Applications for Mediation (25,329 in 2012–13 — a 29 per cent drop from the peak of 35,744 in the previous year). Applications for Arbitration jumped in 2012–13 (a 100 per cent increase from the previous year), likely linked to clearing of the mediation backlog.

Fiscal Year	Mediation			Arbitration		
	Received	Closed	Pending	Received	Closed	Pending
2006–07	13,053	12,480	3,506	2,651	3,040	2,310
2007–08	14,920	13,080	5,347	2,749	2,891	2,163
2008–09	17,233	14,852	7,727	3,045	2,737	2,467
2009–10	22,214	15,825	14,116	3,421	2,931	2,957
2010–11	30,745	18,756	26,105	4,193	3,557	3,593
2011–12	35,744	25,423	36,426	5,260	3,660	5,191
2012–13	25,329	38,434	23,323	10,511	4,956	10,752

¹ Data provided by FSCO's Dispute Resolution Group.



Treatment is the Most Common Disputed Issue

FSCO’s internal DRS database categorizes the type of issues heard in mediations — e.g., medical and rehabilitation benefits, cost of examinations, housekeeping expenses, income replacement benefits, death benefits, interest, etc. Excluding interest, which is generally not the primary cause of a dispute, the top disputed categories for closed mediation files between January 2006 and August 2013 were:

- Medical and rehabilitation benefits
- Assessment and examination expenses (conducted by the claimant’s health care providers)
- Housekeeping and home maintenance expenses.

The September 2010 reforms reduced mandatory accident benefits, which altered the types of issues heard in mediation. The frequency of housekeeping and home maintenance expenses as a disputed benefit have dropped off because they are now only available to policyholders who purchased optional coverage or are catastrophically injured.

The closed mediation file survey gathered additional information to track each benefit in dispute for each mediation file. Out of the 350 files from the closed mediation file survey, there was an average of four disputed benefits per file. Approximately 70 per cent of the disputed benefits may have been added after the original application for mediation was submitted. Excluding interest (claimed for late payment of benefits), there was an average of three disputes per mediation file. Excluding interest, the most common disputes were:

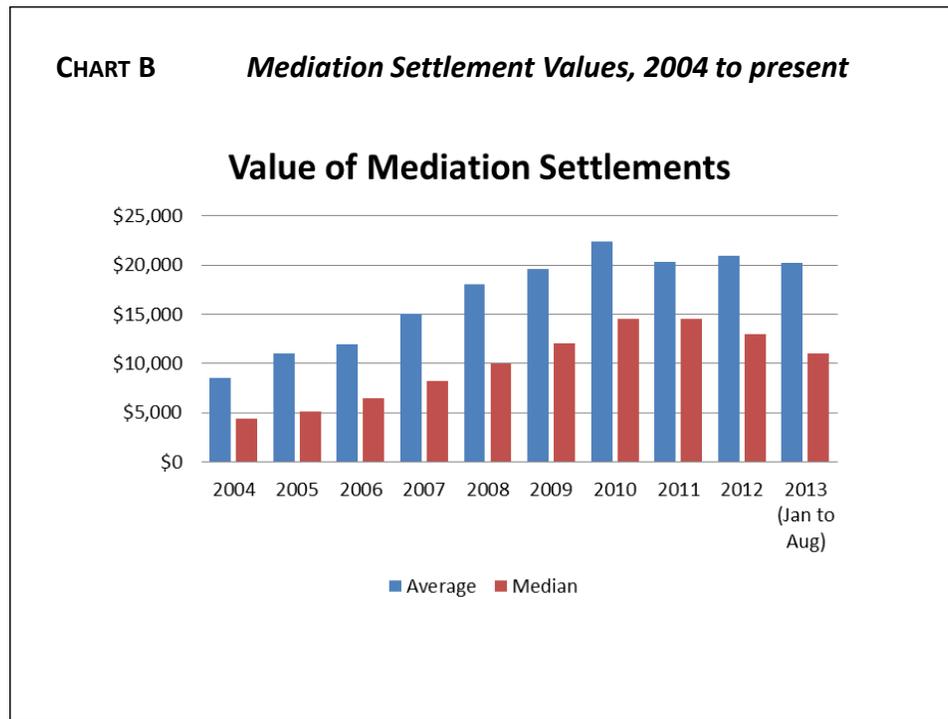
- Medical benefits — 45 per cent
- Assessment and examination expenses — 16 per cent
- Weekly benefits — 11 per cent
- Attendant care benefits — 8 per cent
- Housekeeping and home maintenance expenses — 6 per cent
- Income replacement benefits — 5 per cent
- Rehabilitation benefits — 3 per cent

FSCO's internal DRS database also records the category of disputes that proceed to arbitration. Excluding interest, the top categories for disputes proceeding to arbitration are:

- Medical and rehabilitation benefits
- Assessment and examination expenses
- Housekeeping and home maintenance expenses
- Income replacement and non-earner benefits.

Average Settlement Amounts Have Been Stable Since 2010

Chart B shows how mediation settlement values increased steadily until 2010, and are now hovering around \$20,000 on average. Median settlement values are likely more representative of the size of settlements since many claims are small. Median settlements values fell to approximately \$11,000 for the first eight months of 2013.¹²



¹² All values include lump sum settlements only, and not weekly or monthly benefits that may be paid on an ongoing basis. Lump sums can include weekly/monthly benefits paid out at one time.

Settlements that occurred in the closed mediation file survey did not contain any large settlements (e.g., over \$100,000). The survey's average value of settlements was \$7,818. See Table 2 below.

Table 2: Mediation Settlement Values — DRS system and Closed Mediation File Survey¹				
DRS System			Survey (closed 2012 and 2013)	
Settlement Year	Median	Average	Median	Average
2004	\$4,375	\$8,523	n/a	n/a
2005	\$5,144	\$11,016		
2006	\$6,500	\$11,907		
2007	\$8,250	\$15,063		
2008	\$10,000	\$18,029		
2009	\$12,000	\$19,606		
2010	\$14,500	\$22,431		
2011	\$14,500	\$20,313		
2012	\$13,000	\$20,893	\$5,000	\$7,818
2013	\$11,000	\$20,178		

¹ Data provided by FSCO's Dispute Resolution Group.

A comparison of mediation settlement values pre- and post-2010 reforms, as seen below in Table 3, appears to indicate that the reforms initially decreased the average settlement value or at least stabilized them.

Table 3: Mediation Settlement Values and the 2010 reforms¹				
Settlement Year	Old SABS²		New SABS³	
	Median	Average	Median	Average
2010	\$14,500	\$34,856	–	–
2011	\$14,500	\$20,369	–	–
2012	\$13,500	\$21,724	\$11,750	\$23,456
2013 (Jan to Aug)	\$12,000	\$25,412	\$10,000	\$13,145

¹ Data provided by FSCO's Dispute Resolution Group.
² Based on mediation settlements with Date-of-Loss prior to September 1, 2010.
³ Based on mediation settlements with Date-of-Loss after September 1, 2011.

High Demand for DRS Services from the GTA

The GTA drives much of the demand for mediation and arbitration services. For example, while approximately 50 per cent of auto accident injuries occurred in the GTA between 2008 and 2010, approximately 80 per cent of mediation applications originated in the GTA between 2008 and 2012. A similar geographic split (e.g., ~80 per cent GTA, ~20 per cent outside GTA) is seen in arbitration applications. See Charts C and D, as well as Table 4 for details.

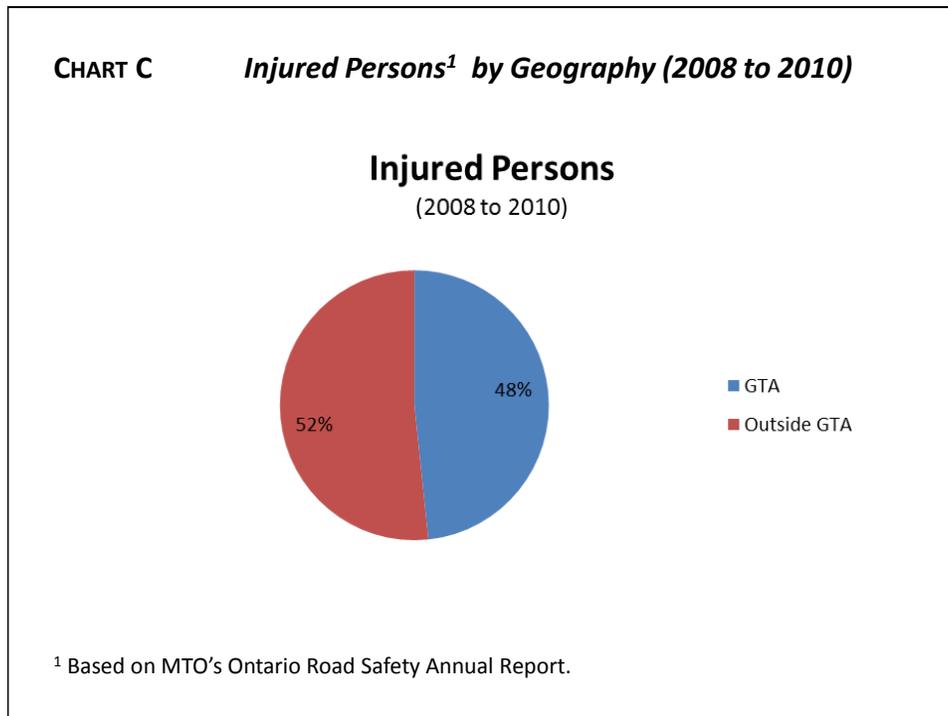


CHART D *Mediation Application by Geography (2008 to 2012)*

Mediation Applications
(2008 to 2012)

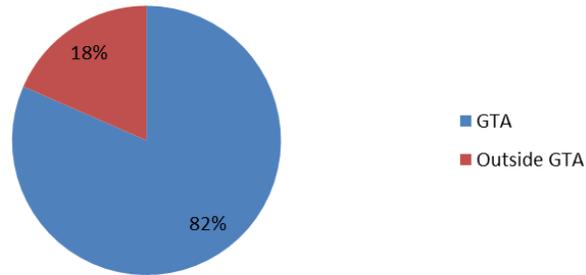


Table 4: Mediation Applications and Injured Persons by Geography

	Injured Persons (2010)	Closed Mediation File Survey (Sept. 1, 2010+)	Mediation Applications (2012)
Greater Toronto	32,969 51%	253 72.3%	22,700 80%
Outside GTA	31,545 49%	97 27.7%	3,681 20%
Total	64,514 100%	350 100%	28,389 100%

¹ Based on MTO's Ontario Road Safety Report 2010.

Table 5 below illustrates how mediation settlement amounts tend to be higher outside the GTA. This may reflect different driving conditions and greater injury severity outside the GTA.

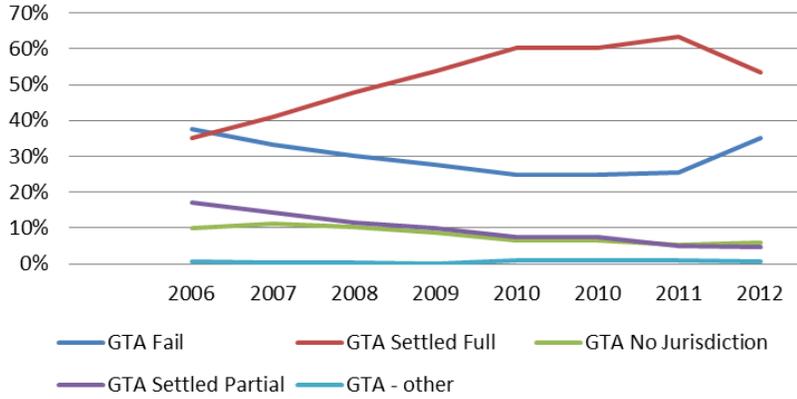
Settlement Year	GTA			Non-GTA			Total		
	No. of Settlements	Median	Average	No. of Settlements	Median	Average	No. of Settlements	Median	Average
2004	2,993	\$4,145	\$7,662	723	\$5,048	\$12,092	3,716	\$4,375	\$8,523
2005	2,829	\$5,000	\$10,083	660	\$6,500	\$15,017	3,489	\$5,144	\$11,016
2006	2,434	\$6,500	\$10,576	581	\$7,000	\$17,484	3,015	\$6,500	\$11,907
2007	3,227	\$8,412	\$11,837	712	\$8,000	\$29,687	3,939	\$8,250	\$15,063
2008	4,155	\$10,000	\$16,028	809	\$9,872	\$28,311	4,964	\$10,000	\$18,029
2009	5,009	\$12,030	\$17,179	930	\$11,050	\$32,683	5,939	\$12,000	\$19,606
2010	6,294	\$14,275	\$19,847	1,112	\$15,000	\$37,059	7,406	\$14,500	\$22,431
2011	7,534	\$14,000	\$18,187	995	\$15,000	\$36,405	8,529	\$14,500	\$20,313
2012	10,798	\$13,000	\$18,227	1,913	\$15,000	\$35,942	12,711	\$13,000	\$20,893
2013	8,561	\$11,000	\$17,078	1,913	\$13,000	\$34,050	10,474	\$11,000	\$20,178

¹ Data provided by FSCO's Dispute Resolution Group.

Both GTA and non-GTA closures have recently experienced an increasing rate of failure, potentially linked to a combination of factors including: clearing of backlog; parties requesting or consenting to fail; effects of the 60-day mediation timeline decision; parties waiting for arbitration/court decisions around the Minor Injury Guideline; and the 2010 auto insurance reforms.

CHART E *Yearly GTA Mediation Closure Types**

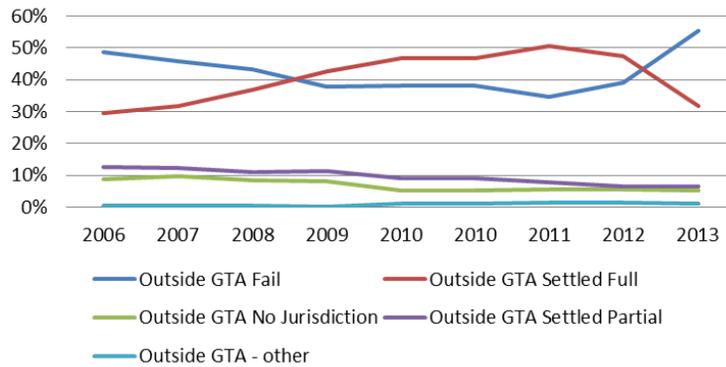
GTA Mediation Closure Types



Fail = failed, failed with parties agreeing to next steps to attempt to resolve the dispute outside of mediation, failed on consent, one party requesting closure after 60 days, failure due solely to dispute on applicability of the MIG.
 No jurisdiction = administrative closures such as two years have passed since insurer denied a benefit claim, mediation did not occur (within first 60 days), no issues in dispute, previously mediated, no entitlement under the SABS.
 Other = uncategorized, incomplete applications, settled prior to registration.

CHART F *Yearly Outside GTA Mediation Closure Types**

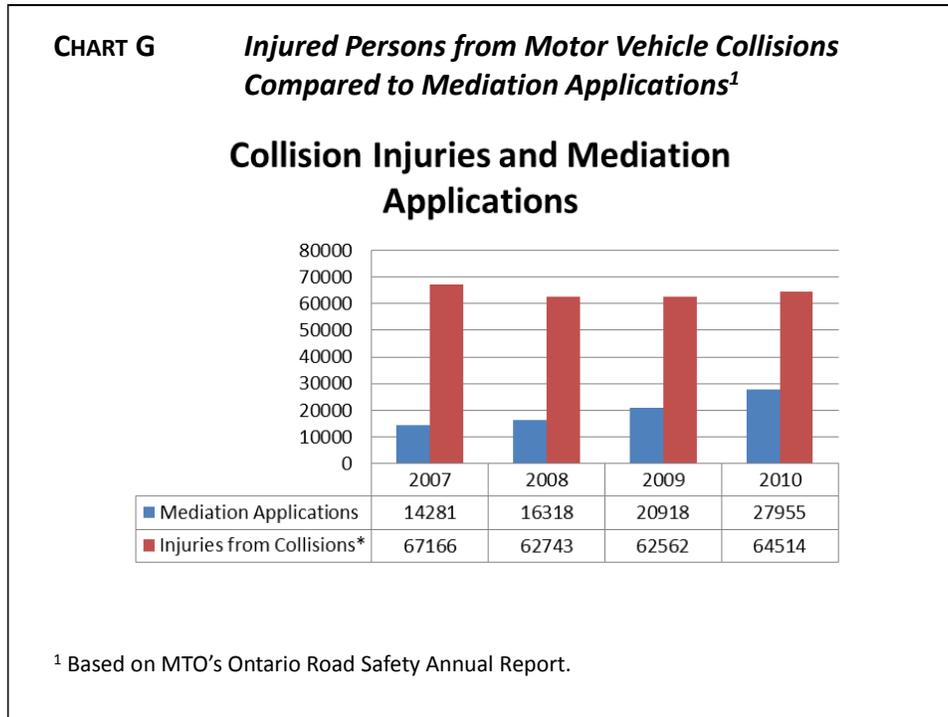
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 Other = uncategorized, incomplete applications, settled prior to registration.

Mediation Applications Have Increased Despite no Increase in MVA Injuries

Although the number of injuries arising from auto accidents as reported by the Ministry of Transportation dropped in the period from 2007 to 2010, the number of mediation applications nearly doubled. As noted earlier in this report, this coincided with sharp increases in benefit utilization, including medical and rehabilitation benefits, housekeeping expenses, attendant care benefits, caregiver benefits and assessment and examination expenses.



When comparing the GTA and non-GTA regions, both experienced significant growth in mediation applications between 2007 and 2011 as illustrated in Table 6 below. In addition, both the GTA and non-GTA regions have experienced similar drop-offs in applications since 2011. Likewise, Table 7 shows that similar patterns of growth in arbitration applications have occurred in the GTA and non-GTA regions.

Table 6: Injured Persons and Mediation Applications by Geographic Area						
	Injured Persons¹			Mediation Applications		
	GTA	Non-GTA	Total	GTA	Non-GTA	Total
2007	27,616 41%	39,559 59%	67,175	10,934 77%	3,347 23%	14,281
2008	28,687 46%	34,056 54%	62,743	12,794 78%	3,524 22%	16,318
2009	30,086 48%	32,476 52%	62,562	16,849 81%	4,069 19%	20,918
2010	32,969 51%	31,545 49%	64,514	23,258 83%	4,698 17%	27,956
2011	-	-	-	30,489 84%	6,019 16%	36,508
2012	-	-	-	22,718 80%	5,689 20%	28,407
2013²	-	-	-	11,203 75%	3,681 25%	14,884

¹ Based on MTO's Ontario Road Safety Annual Report.
² Partial year data from January–August 2013.

Table 7: Mediation and Arbitration Applications by Geographic Area						
	Mediation Applications			Arbitration Applications		
	GTA	Non-GTA	Total	GTA	Non-GTA	Total
2007	10,934 77%	3,347 23%	14,281	2,175 78%	627 22%	2,752
2008	12,794 78%	3,524 22%	16,318	2,253 78%	648 22%	2,802
2009	16,849 81%	4,069 19%	20,918	2,626 79%	685 21%	3,311
2010	23,258 83%	4,698 17%	27,956	3,193 79%	860 21%	4,053
2011	30,489 84%	6,019 16%	36,508	3,887 81%	900 19%	4,787
2012	22,718 80%	5,689 20%	28,407	6,872 82%	1,494 18%	8,366
2013¹	11,203 75%	3,681 25%	14,884	8,732 82%	1,923 18%	10,665

¹ Partial year data from January–August 2013.

Number of MVA Claims Accessing the Courts Has Also Been Increasing

As illustrated by Table 8 below, the number of auto insurance related cases accessing the Superior Court of Justice has been growing. Between 2006 and 2012, the total number of claims received by the court increased by 80.5 per cent. Most of the growth has been in claims in excess of \$100,000.

Table 8: Number of MVA Claims Received by the Superior Court of Justice, Civil¹							
	2006	2007	2008	2009	2010	2011	2012
Total Claims Received	13,028	13,177	13,758	14,377	15,058	19,815	23,521
Monetary Amount							
\$0.01 – \$10,000	111	82	141	137	105	281	642
\$10,000.01 – \$25,000	159	194	164	84	22	14	22
\$25,000.01 – \$50,000	286	283	282	199	59	69	95
\$50,000.01 – \$100,000	493	479	309	187	451	813	776
Over \$100,000	9,823	9,705	10,736	9,879	11,136	16,915	19,871
No Amount Entered	2,156	2,434	2,126	3,891	3,285	1,723	2,115
¹ Based on data provided by Court Services Division, Ministry of the Attorney General.							

Preliminary Observations and Recommendations

I found the research of other dispute resolution systems and discussions with system stakeholders informative. In my discussions with stakeholders, I found that many have been working within the system for a long time and have developed an affinity for the system despite some frustrations with it. Most agreed that changes are necessary, but there is no consensus regarding the scope of possible reforms. I made it clear I was being open-minded with respect to the extent changes may need to be made to address the system's problems.

I was asked by the government to make some early recommendations, which can be found later in this report. As well, the report includes some preliminary observations regarding the DRS during the initial phase of my review. Many of these observations will be considered further as I prepare to make recommendations in my final report. Below are a number of principles with respect to dispute resolution under which I have summarized my observations.

Timeliness

The DRS was created to provide quick access to dispute resolution services without the need to go to court. This was intended to promote timely treatment. My understanding is that, when volumes were more manageable in its early days, the system worked. Further evidence of this was the awarding of the prestigious Amethyst Award for outstanding achievement by the Ontario Public Service to FSCO's Mediation Unit in 1998.

To a certain extent, the system has been a victim of its own success. Easy access, in addition to other factors, has created demands for services leaving FSCO struggling to keep up. FSCO's mediation backlog over the past several years has highlighted a problem that has plagued the system for some time: it takes too long to resolve disputes. Not only has it taken too long to appoint a mediator and schedule a mediation, it also takes too long to schedule arbitration pre-hearings and hearings and the timeframe for releasing decisions has grown over time. To illustrate how long it now takes to resolve disputes, consider that three years have passed since the last round of auto insurance reforms, yet virtually all disputes regarding the interpretation of the new SABS have still not reached arbitration. Contrary to the original intent, FSCO's DRS has turned into a system parallel to the courts. Timeliness, which was once an attractive feature of the system, has been lost.

Even the hearing process in Ontario has become protracted. FSCO hearings can stretch out to weeks while in many other jurisdictions a typical hearing lasts no longer than a day. In New York State, which has a combined tort and no-fault system, there are more than 150,000 arbitration applications filed in a year and, typically, the time from the application date to an arbitration decision is six to nine months. In Manitoba, which has a pure no-fault system, the entire process takes less than eight months, including issuing a decision.

The lack of timeliness has an impact on the system and participants beyond just delayed resolution of claims. Obtaining funding to pay for treatment becomes a challenge. In some cases, health care providers are willing to wait until the outcome of a dispute. If there is a tort claim along with an accident benefits claim, the lawyer may attempt to get funding from a litigation funding company¹³ or through an advance from the insurer.

A form of queue-jumping has developed, where mediation applications are filed early in the claim process in anticipation of a future benefit denial. The delays in the system have meant a claimant has months to provide details regarding the benefits in dispute or withdraw the application at no cost in the event that no dispute arises. Long delays mean additional issues can be added to the dispute as claims continue to progress and the file is built up for an eventual settlement. If insurers are ultimately found to be liable to pay the disputed benefits, interest may be owed, as well, at one per cent per month, compounded monthly. Claimants' lives can be put on hold for years waiting for resolution of their claims.

Legal representatives can also become barriers to speedier resolution of disputes. Many have busy schedules and are unable to commit to a pre-arbitration session or arbitration hearing until many months into the future. An adjournment or delay pushes back a final resolution further. I find the open-endedness of the arbitration process to be problematic. In addition, I am troubled by the practice of some legal representatives who choose to shield claimants from insurers. When insurers cannot talk to their own customers, it impacts on customer service and can prevent an earlier resolution of disputes.

I believe the system has lost its ability to provide a speedy resolution of disputes, which was one of its founding principles. I support the principle that dispute resolution services should be delivered in a timely fashion. One way to accomplish this is to establish delivery standards with respect to timelines. While the Practice Code developed by FSCO's Dispute Resolution Group does set delivery standards, they are not being met. The lack of statutory time limits for scheduling arbitration pre-hearings and hearings is a design flaw in the system.

¹³ A litigation funding company provides cash advances to litigants to finance their litigation and other expenses in exchange for a percentage share of the settlement of judgment.

Proportionality

Many stakeholders expressed the view that the current DRS lacks proportionality. Every dispute receives the same treatment within the DRS, whether \$50 or \$50,000 in benefits is being disputed. Therefore, expenses incurred by claimants, insurers and FSCO to resolve a dispute can become disproportionate to the actual expense in dispute.

Insurers are assessed \$500 for mediation and \$3,000 for arbitration. This does not include preparation costs or the cost of legal representation and expert reports. So, for example, when facing a dispute regarding \$1,000 in chiropractic expenses, it may make economic sense for an insurer to settle the claim even if the claim has no merit. Sometimes, insurers are tested to determine their tolerance to settle and close claims rather than proceed to arbitration. In many cases, these expenses are legitimate and should be paid. In cases where expenses may be frivolous or unreasonable, insurers have suggested that settling these claims adds unnecessary costs to the system and puts upward pressure on auto insurance premiums for other drivers in the province.

In addition, it may be excessive to require an in-person hearing in all cases — for example, to determine whether a \$1,200 orthopaedic mattress is a reasonable and necessary expense. Many of the jurisdictions I looked at provided paper review arbitrations as an alternative to in-person hearings. In some jurisdictions, the parties can request a paper review and, in some cases, the determination is made by the arbitrator based on a review of the file.

I would like to see a future system that could accommodate different processes based on the complexity of the case. An expedited process for simple cases or those where the benefits in dispute are below a monetary threshold (e.g., \$25,000) makes a lot of sense.

Accessibility

As I have previously noted, accessibility to the DRS to facilitate timely access to treatment was an important principle for policymakers when the system was being designed. The large number of mediation applications over the past five or six years suggests accessibility is not a problem. In fact, some would suggest that there is too much access to the system.

There are few disincentives in the system to dispute a benefit denial. Mediation is free for claimants and arbitration costs only \$100. There are many legal representatives working on a contingency basis, which means there are no financial risks for the claimant who wishes to challenge an insurer's decision regarding benefit entitlement. Efforts to screen out or remove frivolous or undocumented disputes early in the process appear to be ineffective. I would not necessarily like to see the introduction of financial barriers, which might dissuade an individual with a legitimate claim from accessing the system. Perhaps if the costs were at the back end of the process instead of the front end, they could provide some balance to the system by penalizing those who abuse it.

One thing that has been pointed out to me and with which I would have to agree is that Ontario's auto insurance system is extremely complicated. Addressing the complexity of the system is not part of the mandate of this review, but it is a consideration in addressing the problems with the current DRS. Not only is the SABS complicated, but so are the forms required to be completed by claimants to apply for benefits or for mediation and arbitration.

In its early days, many claimants accessed the DRS without a representative. This is no longer the case. Lawyers and paralegals provide an element of consumer protection because they have a good understanding of the SABS, the claims process and the dispute resolution process. They also provide a counterbalance to the resources available to insurance companies. However, legal representation is not free and not necessarily inexpensive. Legal representatives are charging SABS claimants contingency fees, which I am told can be as high as 30 or 35 per cent. This is money out of the pockets of claimants who need these funds to replace lost income and pay for treatment.¹⁴

¹⁴ In claims where fees are being paid to another lawyer for a referral, this further reduces funds available to the claimant.

While reviewing other jurisdictions, I found that some systems have addressed this issue in part by providing claimants with free advocacy services. The Automobile Injury Compensation Appeal Commission in Manitoba has a Claimant Advisory Office that provides claimants with claimant advisers. The Ontario Ministry of Labour has an Office of the Worker Adviser that provides similar advocacy services to workers with Workplace Safety and Insurance Board (WSIB) claims. In these other systems, claimants may still use lawyers, which makes sense for complex and serious claims. The use of advocacy offices as an alternative to legal representatives may make sense when claims are small.

Predictability

I am told one of the contributing factors to high auto insurance rates in Ontario is lack of predictability in the auto insurance system. Funds are set aside to cover the costs of each claim based on the type of injury sustained. The interpretation of some regulatory reforms introduced in 2010 have yet to work their way through the DRS or the courts. Interpretation of the “minor injury” definition and the “incurred expense” definition are two of the more significant issues being challenged in the system. Because of this uncertainty, more funds are reserved to pay claims than might otherwise be the case. Some in the insurance industry would like to stop the practice of publishing arbitration decisions. If there were no published decisions, I would expect this would remove an element of predictability from the system.

Following previous reforms, claim costs dropped only temporarily. The insurance industry points to a number of arbitration decisions that have been inconsistent with the policy direction of the government. Clearly, the role of arbitrators and tribunals is to provide adjudicative services and not to set policy. Some tribunals recognize that there are situations where arbitrators may have difficulty in deciding a case because the policy is unclear. Section 126 of the Workplace Safety and Insurance Act sets out how the Workplace Safety and Insurance Appeals Tribunal (WSIAT) is to apply WSIB policy in the appeal process and the procedure in the event clarification is needed. I would like to see a similar separation of policy and adjudication in the auto insurance system.

There are other mechanisms, which I observed in our jurisdictional review, that contribute to more consistent adjudication. New Jersey, for example, provides their arbitrators with access to independent medical consultants to review files and provide opinions on appropriate treatment. This type of mechanism provides arbitrators with a neutral benchmark for generally-expected treatment and recovery times for injuries and claims. I understand that the former designated assessment centres provided this type of input but the costs were too high. I believe a lower-cost model could be developed. This could reduce the need for expert witnesses in some cases, and provide arbitrators with objective opinions regarding evidenced-based treatment of common injuries. I also see some potential pitfalls with respect to a process for providing neutral medical opinions to arbitrators. This additional step will add costs and draw out the process. I am not sure how to find medical consultants who will be considered neutral by all the users of the system. However, I look forward to learning more about this possible feature during the next phase of my review.

In addition, some jurisdictions produce lists of acceptable treatments, which reduces some of the uncertainty and the number of disputes around what is reasonable and necessary treatment.

I understand FSCO has contracted with medical and scientific researchers to develop a comprehensive treatment protocol for minor injuries. Some stakeholders believe that the new protocol, which is expected in 2014, will reduce disputes in the system.

Streamlining

During my discussions with stakeholders, I heard numerous suggestions for streamlining the dispute resolution process. It has been pointed out that FSCO's current process is only marginally faster than the courts. It was suggested that the length of arbitration hearings be limited, as well as the number of witnesses. As previously discussed, introducing arbitration hearings involving only paper review would also streamline the process. Yet other suggestions I thought could have the opposite effect. For example, it was suggested that all mediations should be in-person in order to improve settlement rates, but I'm concerned this would further slow down scheduling. I understand the importance for insurers to be able to meet face-to-face with claimants. This is sometimes not practical, but today technology such as video conferencing can adequately address this issue.

I am more concerned about the number of mediations taking place where there is no prospect of a settlement because of the complexity of the claims or the issues in dispute. The parties simply go through the motions in order to move the process to the next step. Some stakeholders did suggest combining the mediation and arbitration processes, which I will discuss later in the report.

The insurance industry has some strong views about health care providers using the DRS to collect payment for invoices. I have been told that claimants often do not actively participate in disputes involving treatment and, in some cases, are not even on the call during telephone mediations. It has been suggested to me that health care providers should somehow be barred from using the system for this purpose.

I have a different perspective on the issue of health care providers accessing the DRS. Despite the fact that a contract of insurance exists between insurer and claimant, the relationship between insurers and health care providers has been formalized for years. Health care providers are permitted to bill insurers directly, but there is no formal process available to them to dispute denied accounts.

Treatment plans and assessment requests are completed and submitted by health care providers. The provider is in the best position to communicate an explanation of why the denied services are reasonable and necessary. I'm not convinced that dragging the claimant into the dispute provides much value. I think this is recognized in some U.S. jurisdictions, which allow for assignment of benefits to health care providers. In those jurisdictions, health care providers can dispute a denial of benefits as long as the claimant has assigned benefits to the provider. If health care providers were permitted to initiate a dispute in Ontario, they could be asked to pay the costs, instead of the current situation where they indirectly access the system at no cost through a claimant.

The system can be further streamlined by eliminating the little-used neutral evaluation stage that was introduced in 1996. I see a merged mediation-arbitration model providing evaluative input to the parties when warranted early in the process. As well, the appeal to the Director's delegate could also be eliminated. The small number of appeals could be handled by a single judge of the Superior Court.

Costs

When speaking with the insurance industry, the comment I often hear is that the claimant needs to have “some skin in the game.” This is in reference to the perception that the system is weighed too heavily in favour of claimants. I am told that when the DRS was being developed in the early 1990s, it was designed to accommodate unrepresented claimants and ensure that insurance companies didn’t use their superior financial resources to overwhelm individual claimants.

Consequently, there is no cost to the claimant when applying for mediation services while insurers must pay \$500. There is a \$100 application fee for claimants who file for arbitration, while the insurer must pay \$3,000. I understand why the cost structure was designed this way. One does not want to create monetary barriers for claimants seeking benefits to which they may be entitled. Yet there appears to be a need for some economic disincentives to prevent abuse of the system.

The cost structure is often used to leverage settlements from insurers. Insurance companies also contribute to the problem because of their desire to close files on a full and final basis. The practice of paying lump sums for estimated future losses is borrowed from the tort system but does not exist in some other benefit systems, such as workers’ compensation.

Other systems also provide access to dispute resolution at no or little cost to claimants. Where the Ontario auto insurance system varies is the cost to insurers. The combined cost of \$3,500 for mediation and arbitration well exceeds other systems. In New York, the applicant pays \$40 and the insurer approximately \$350. In Minnesota, the applicant pays an initial application fee of \$35 and the insurer \$130. The \$300 arbitration fee in Minnesota may be split between the parties or, in some cases, the arbitrator may direct one of the parties to pay it as part of their decision. Bear in mind that claimants are already funding the system through premiums and we need to maintain proper access to justice, but users should pay something so the system is not abused. Perhaps some individuals could have their payments refunded under certain circumstances. Unlike in the courts, I did not find a system that assigned costs to a claimant following an unsuccessful arbitration.

I believe a more level playing field could be created by streamlining the system in order to reduce costs. A more cost-effective system would reduce some of the incentives to pursue frivolous claims.

In addition, the mediation and arbitration assessments do not always reflect the service being provided. I question whether the full \$500 mediation assessment should be paid when no mediation takes place, or whether the full \$3,000 arbitration assessment should be paid if the claim settles before a hearing. Perhaps fees might be graduated based on how far the claim advances in the system.

Culture

I am struck by the culture that has developed within the auto insurance system and how it has impacted the DRS. There are many excellent practitioners operating in the system, but there are also those who seem almost to undermine the system. Insurers complain about lawyers who deny them access to documents to substantiate a claim or the ability to examine the claimant by an assessor provided by the insurer. These tactics serve only to delay the resolution of disputes. I heard complaints about parties arriving unprepared for mediation, which undermines the process and makes it more difficult to resolve disputes. I believe some of the lack of engagement relates to the limited authority provided to mediators. However, unprepared parties reflect a lack of respect for the process and should be subject to some form of sanction.

I have spoken to a number of insurance companies and asked what they can do to resolve disputes earlier. The answer frequently is “we are doing all we can.” I think more can be done early on in the process to avoid protracted disputes. I have been told front-line claims adjusters can be inexperienced with high caseloads. In this type of environment, I would suggest information can, at times, be missed or misinterpreted. I understand caseloads for claims adjusters range from 35 files to 200 or more. I suspect higher caseloads have an impact on decision-making and the DRS.

Although I sympathize with the insurance industry’s desire to close files on a full and final basis, I find the practice in some circumstances counter-productive. It only encourages the type of behaviour insurers have raised with me during this review. Other insurance systems, such as workers’ compensation or supplementary health plans, will never, or only in exceptional cases, pay a lump sum for future health care benefits. I would support extending the one-year prohibition on settlements if it would have an impact on the “cash for treatment” mentality that currently exists. Disputes and settlements need to be focused on getting claimants timely access to necessary treatment and assessments.

Something needs to be said about the culture within FSCO’s Dispute Resolution Services. The mediators and arbitrators collectively are very knowledgeable on SABS issues and have many years of adjudicative experience. FSCO’s mediators and arbitrators work for the Ontario Public Services and are represented by a bargaining agent/union. Under the existing structure, I believe it must be very challenging for FSCO to maintain high performance levels without influencing arbitrators and thereby compromising their independence. A number of stakeholders have expressed concern about FSCO’s role as a regulator of the insurance industry and, at the same time, adjudicating disputes between insurers and claimants.

The appointment of arbitrators is set out in section 8 of the *Insurance Act*, which requires the Superintendent to establish a roster of arbitrators recommended by a committee established by the Minister of Finance. Section 9 of the Act authorizes the Superintendent to appoint FSCO staff or other persons as mediators. It appears the Act contemplated a roster of arbitrators but not necessarily government employees. The Act also contemplated mediators being both government employees and external individuals. Until the contract with ADR Chambers, all mediators and arbitrators were employees of FSCO.

The appointment process for arbitrators is worth noting. FSCO follows standard Ontario government recruitment practices when hiring arbitrators. When the selection process is completed but before making offers, candidates are referred to the Minister's committee (made up of FSCO senior managers) for review and subsequent recommendation to the Superintendent.

FSCO has 36 mediator and 21 arbitrator positions. When demand for services increases, FSCO has no flexibility from within its current head count to respond, and the process for approving additional head count is restrictive.

I am told that FSCO has difficulty applying certain procedural provisions of the SABS. The most frequent example I have been given is the lack of enforcement of section 55 of the SABS. Section 55 denies a claimant access to mediation until they have complied with a request by an insurer to attend a medical examination under section 44. By not dealing with these types of issues early, FSCO staff are indirectly prolonging disputes.

In some cases, FSCO's DRS adjudicative and regulatory functions appear to be in conflict. An example involved two recent arbitration decisions¹⁵ indicating FSCO's Settlement Disclosure Notice did not comply with the regulation. FSCO followed up with a notice to stakeholders stating that the form did comply with the regulation. Later, FSCO published a revised Settlement Disclosure Notice to ensure compliance with the regulations. I believe these decisions illustrate how the different roles within FSCO can conflict and only confuse stakeholders.

¹⁵ *Shamima Parveen and Aviva Canada Inc. and Joshua Fredric and Aviva Canada Inc.*, FSCO A10-002767 (March 30, 2012).

Mandatory Mediation

I found no consensus among stakeholders on this subject. Some are of the view that mandatory mediation can become a roadblock to early dispute resolution by dragging unwilling participants to mediation sessions. They suggest if mediation were voluntary, it would be more meaningful because those participating would be more motivated. Yet others insist it should remain mandatory because a large number of disputes are resolved at the mediation stage, which eliminates the need to go to arbitration where costs are much higher. There were also concerns expressed that mediation would be avoided if it were made voluntary.

Almost everyone I spoke to agreed that certain claims rarely settle at the mediation stage. Those claims include catastrophic determination, disputes over home modifications and larger disputes over entitlement to income replacement or non-earner benefits. It was also suggested that disputes concerning smaller amounts may not need formal mediation such that many disputes could be resolved more quickly than through the existing mediation process.

Mediation resolves 50 per cent of disputes, which suggests the process does have value. More than 90 per cent of arbitration files are settled without a hearing, often at the pre-arbitration stage. Combined, the two steps resolve a great many disputes and although the steps are different, the objectives are the same. Under the current system, mediators do not have a full range of powers with which to facilitate resolutions. I envision a DRS where the front end contains a more evaluative and involved intervention. Non-compliance by the parties must be addressed early on.

The government asked me to recommend whether mediation should remain a mandatory part of the DRS. For me, the real issue to be addressed is the role mediation should play in the system. I would like to see a new process developed that uses the strengths of mediation and arbitration together to create a more streamlined and efficient model. A more compressed, speedier process could see mediation and the pre-arbitration hearing take place at the same time before an arbitrator. Those who do not settle would move directly to arbitration. I see a gatekeeper function as being an important feature of a new model. Each incoming case would be reviewed to determine: if the parties are ready to enter the system; if there are jurisdictional issues to be addressed; if there are multiple applications from the claimant that might be consolidated; and if the production of documents has taken place.

Almost every system I looked at provides claimants with the opportunity to request an internal review by the insurer following a benefit denial. The internal review process provides a “second set of eyes” to confirm that the original decision was correct. Internal review processes vary by insurer, but conceptually, the process might confirm the original decision, reverse the decision or send the file back to the original decision-maker for reconsideration. New information could be provided by the claimant at the internal review stage. Only after this process takes place should a claimant be entitled to initiate a dispute. During my discussions with stakeholders, I learned some insurance companies have actually established such a process. They have done so because they do not want to alienate their customers, and understand not only the importance of resolving disputes early, but also the importance of customer retention. I would like to see this step formalized and adopted across the industry.

I recommend that mediation no longer be mandatory in its current form. I further recommend that the government consider introducing a new system that consolidates the strengths of the existing mediation and arbitration processes to facilitate a more efficient model for resolving disputes. I will explore the details of that system through further consultations, and will report back with recommendations in my final report.

Private vs. Public

I am concerned about the conflict between the regulatory and the DRS adjudicative functions within FSCO and believe a separation is warranted. What needs to be determined is whether FSCO’s dispute resolution functions should be relocated to another public sector body or to the private sector.

There was strong support among stakeholders for moving dispute resolution to the private sector. There was also support for creating a tribunal model similar to the Workplace Safety and Insurance Appeal Tribunal and the Automobile Injury Compensation Appeal Tribunal in Saskatchewan. There is a consensus that an advantage of the existing system at FSCO is that the mediators and arbitrators have a very good understanding of the SABS. Any new system must provide decision-making based on a solid understanding of the SABS.

Many Ontario public sector tribunals are Order-In-Council (OIC) appointments and the adjudicators are paid on a per diem basis. FSCO’s mediators and arbitrators seem to be an exception and are salaried, bargaining agent-represented public servants. There does not appear to be a current rationale for this structural difference.

Some stakeholders proposed establishing large rosters of private sector mediators and/or arbitrators to replace those at FSCO. In this model, the parties in a dispute would agree on someone from the roster to arbitrate their dispute. I have concerns about the lack of discipline under such an approach. I prefer a contracted service delivery model. The overseer would be responsible for training, quality control and meaningful standards based on legislated requirements. In this fashion, efficiency could be increased and access to timely and necessary treatment enhanced. I also believe that there may be an opportunity to find cost savings in new merged model. A contracted service delivery model will provide more flexibility to respond to varying demand.

I believe a future system also needs to provide some gatekeeper or triage function to keep the parties honest and to identify cases that might need fast-tracking. I am not sure this will occur under a roster system. As well, there should be a premium on having decision-makers who are knowledgeable about the SABS.

Wherever this body exists, it needs to be properly resourced so it can quickly respond to changes in demand for services. It is inevitable that Ontario's auto insurance system will undergo further reforms and that these changes will impact the demand for dispute resolution services.

I see no reason why the DRS adjudicative function needs to be housed at FSCO. I recommend that the government consider that FSCO's DRS adjudicative functions be delivered externally. In my final report, I will address whether the adjudicative functions should be established in an independent public sector tribunal or in the private sector.

A Framework for Possible Legislation

Although I will not make recommendations beyond those already addressed in this interim report, I would like to offer the components of a possible new model. I want to provide participants and stakeholders with the opportunity to comment further as I prepare my final report. My objective is to propose a model covering the principles of timeliness, proportionality, accessibility, predictability, streamlining and cost efficiency while promoting a positive culture. I have been asked for recommendations regarding possible legislation. Here are my tentative views.

I envision a process that takes no longer than six months from start to finish. Cases would follow a different stream based on the benefits in dispute and the complexity of the issues involved. Ensuring access to timely and necessary treatment would be a first principle. The system would stop trying to mirror the courts and provide speedy, predictable and lower-cost adjudication. As well, parties not following these principles would be penalized.

The process would begin with a benefit denial. I would like to see every Ontario auto insurance company establish a formal internal review process. A claimant wishing to dispute a benefit denial would first have to meet with their insurer to clarify why they believe the insurer was incorrect and present any new information to support their claim. This process would have to take place within a 30-day window.

If the parties cannot resolve their dispute, the claimant would then be free to file an application with the new ADR body (whether in the private sector or within a tribunal) or perhaps they could access the courts at that stage. Cases using the court option would be subject to the rules and timelines of the court system. If the claimant chooses ADR, a case manager serving as a gatekeeper to the process would review each application to determine whether the parties are ready to proceed through the system. The case manager would determine whether there are jurisdictional issues to be addressed and whether a proper exchange of documents has taken place. The case manager would have the ability to return the application if there were any outstanding issues. If the application were deficient, the case would lose its place in the queue.

Once everything is in order, the case would immediately be assigned to an arbitrator, who would arrange a mediation session within 45 days. I see the mediation session as a hybrid of the current mediation process and pre-arbitration hearing. During this stage, the arbitrator might provide a non-binding opinion on the likely outcome; in other words, the mediation session could potentially be a more evaluative process. Should the mediation fail to produce a settlement, the arbitrator would immediately schedule a hearing for the parties. The scheduling could conceivably occur at that time.

The arbitrator would also perform a triage role at this point to determine whether the case should be subject to a paper hearing, an expedited summary in-person hearing or a full in-person hearing. For a paper hearing, I see the parties submitting their final positions in writing along with all supporting documentation, and the arbitrator making a decision based on a document review. For an expedited in-person hearing, the parties would submit supporting documentation, including affidavits and expert reports. Although testimony and cross-examination could take place within set time parameters, the use of expert witnesses would not be permitted. Expedited hearings would take no longer than half a day. More complex cases, such as catastrophic impairment determinations, would be permitted to make use of expert witnesses but still would be limited to a short timeframe. The paper hearing would take place within 60 days of the mediation, while in-person hearings would take place within 90 days. Prior to the hearing date, a case manager might contact the parties to explore settlement possibilities and to determine whether some issues could be resolved before the hearing.

I would like to see rules established, perhaps in regulations, setting out timelines, sanctions for non-compliance and other provisions to ensure the parties follow the principles I have set out in this report. There should be a prohibition on adjournments in all but the most exceptional cases. The length and content of expert reports should be restricted. Reports need to get to the point and focus on the issues in dispute. Each case should be decided on the merits of that case alone. Arbitrators should be required to follow the policy intent of the regulations and the Superintendent's interpretive guidelines. Arbitrators should have discretion to assign costs to either side when warranted. Fees may differ depending on the type of hearing.

Decisions should be issued within 45 days of an in-person hearing. For paper hearings, decisions should be issued within 30 days. The process from application date to the issuing of a decision would be four and a half months for paper arbitrations and six months for in-person arbitrations.

There should be the ability to fast-track some issues through the DRS and ultimately through courts, if necessary, to obtain early rulings in relations to new amendments to the SABS.

The final component of my proposed model would be an appeal process. I would like to see appeals heard by a single judge of the Superior Court.

Appendix A — Jurisdictional Scan

British Columbia

British Columbia has had a government-run auto insurance system since 1974, operated by the Insurance Corporation of British Columbia (ICBC). Mandatory coverages provided through the ICBC are no-fault accident benefits, third-party liability, under-insured motorist protection, hit-and-run protection, and inverse liability. Optional coverages can be purchased from the ICBC or private insurers.

Any ICBC decision can be disputed. A claimant can speak to a supervisor or claims manager at the office involved in respect of a claims denial. If the claimant is still not satisfied with the outcome, they may be referred to ICBC's Claims Coverage Committee.

After this internal review, a dissatisfied claimant's only recourse is to take the ICBC to court.

In 2014, the British Columbia government will be establishing a new dispute resolution and adjudicative body. This Civil Resolution Tribunal will have authority to hear some strata property disputes and, where the parties agree, small claims matters. However, it will not be dealing with auto insurance disputes.

The new Civil Resolution Tribunal will provide an alternative to the traditional dispute resolution services of the B.C. Provincial Court's small claims division. The tribunal will use a mediation-arbitration model, with the focus on informal and flexible dispute resolution processes. There will be a case-management phase and a tribunal phase. However, if the case manager is a tribunal member, the case manager may offer direct and final resolution of the dispute if the parties agree. It is expected that most parties will represent themselves.

Alberta

The only dispute resolution process in Alberta with respect to auto insurance deals with disputes over calculation of premiums. There is no special process to deal with accident benefit disputes. To dispute a decision of an insurer, claimants must go to court.

Saskatchewan

Saskatchewan has had a government-run auto insurance system since 1945, operated by Saskatchewan General Insurance (SGI). Since 2003, consumers have been able to choose between a pure no-fault auto insurance product (which means there is no ability to sue a third party) and a tort product (which has some no-fault benefits).

To dispute a SGI claims decision, a claimant can choose to attend mediation or go directly to either the Automobile Injury Appeal Commission (AIAC) or court. If the claimant chooses to file an appeal with the AIAC, they must do so within 90 days from the date of SGI's written decision, or if mediation has been elected and is unsuccessful, 60 days from the date of the mediation completion statement.

Claimants who have tort coverage cannot appeal to the AIAC and must go to court to dispute a SGI decision.

Following a hearing at the AIAC, a claimant can only appeal a decision to the Saskatchewan Court of Appeal if it is a question of law.

Manitoba

Manitoba has had a government-run auto insurance system since 1971, operated by the Manitoba Public Insurance Commission (MPIC), a non-profit crown corporation. Manitoba has had a pure no-fault system since 1994.

Manitoba has a two-step appeal process for injury claims: a review by MPIC followed by a review by a third-party organization. The first step involves an internal review by a review officer who can reverse a decision made by a case manager. A request for an internal review must take place within 60 days of a case manager's denial. The review officer reviews the file, but will meet with the claimant if requested.

A claimant can appeal the decision of an internal review officer by filing with the Automobile Injury Compensation Appeal Commission (AICAC) within 90 days of the decision. Appeals may be heard by a single Commissioner or by a panel of three Commissioners. Claimants may represent themselves or be represented by a claimant adviser or a lawyer. The Claimant Adviser Office is an advocacy office, completely independent from MPIC and AICAC, that was created to help people who want to appeal MPIC internal review decisions. AICAC decisions are typically provided on the day of the hearing with a written decision provided within 60 days.

The only remaining avenue available for an appeal is the Court of Appeal, but only with respect to a question of jurisdiction or of law, and only with leave obtained from a judge of the Court of Appeal.

Québec

Quebec has had a government-run auto insurance system since 1978, operated by the Société de l'assurance automobile du Québec (SAAQ). Québec also has a pure no-fault system.

A claimant can apply to have a SAAQ decision re-examined by applying for an internal review within 60 days of the denial. The review officer can obtain additional medical, legal, financial or other documents, or require a medical assessment. The SAAQ has 90 days to render a review decision. If the SAAQ must obtain documents or have an assessment made by a health care professional, the SAAQ then has an additional 90 days to render a review decision. A claimant has the right to appeal a review officer's decision within 60 days to the Tribunal administratif du Québec (TAQ).

The TAQ has been in existence since 1998 to review decisions of government departments, agencies (including the SAAQ) and municipalities. In most proceedings, the TAQ will offer the parties the possibility of participating in a conciliation session (mediation) to facilitate a settlement. Hearings involving SAAQ decisions are heard by a panel of two judges, one of whom is a lawyer or notary, and the other a doctor, social worker, psychologist or a member of another profession, depending on the case. The TAQ has 90 days to issue a decision.

Nova Scotia

There is no special process to deal with disputes over no-fault benefits. To dispute a decision of an insurer, claimants must go to court.

New Jersey

New Jersey has had a privately delivered no-fault auto insurance system since 1973. New Jersey is similar to Ontario with an ability to sue for bodily injury liability if one meets a verbal threshold. In New Jersey, a policyholder can purchase optional coverage that allows one to sue without meeting the verbal threshold.

New Jersey has established an arbitration process to deal with disputes between medical providers and auto insurers. Forthright Solutions currently has a three-year contract with the New Jersey Department of Insurance and Banking to resolve these disputes. The proceedings are governed by rules developed by Forthright and approved by the Department of Insurance and Banking.

All medical treatment must be precertified (prior approval) by the insurer to be payable without dispute. If the insurer denies treatment after a precertification request, it is still payable if later found to be medically necessary. A 50 per cent penalty applies if the treatment was not precertified even if the treatment is found to be medically necessary.

If treatment is denied due to medical necessity, usually as a result of an independent medical assessment, arbitration is required to compel payment. Each insurer also has an internal appeal process which is to be accessed before filing for arbitration. Both parties pay a fee of \$225 to participate in arbitration. For a medical provider to access arbitration, the claimant would have to assign their benefits to the provider. If the dispute is for less than \$1,000 and there is no claim for future benefits, the dispute is subject to a paper review and each party pays a fee of \$200. If the dispute is for more than \$1,000, a hearing is set up. Approximately 20 per cent of arbitrations have been paper reviews since they were introduced on March 1, 2013.

In addition, any party may request a panel of three arbitrators if the aggregate amount claimed exceeds \$50,000. The cost of the panel is an additional \$500, which is either paid for by the requesting party or can be split if the parties agree. An award or order can also be appealed to a panel of three arbitrators by either party. The party filing an appeal will pay a fee of \$630.

Either party or the arbitrator may also request that a certified Medical Review Organization (MRO) designated by the New Jersey Department of Banking and Insurance be used to perform a medical review. These are peer paper reviews and do not involve an examination of the claimant. A fee of \$100 is charged by Forthright to process these requests in addition to the fee charged by the MRO health care consultant, which is approximately \$1,000.

MROs are also used in cases where an insurer denies treatment as not medically necessary. The claimant or provider may request an expedited determination of medical necessity by a MRO. If the MRO concludes the treatment is not medically necessary, then the claimant or provider may proceed with arbitration. The determination of the MRO health care consultant is presumed to be correct by the arbitrator; however this presumption may be rebutted by a preponderance of evidence. In reality, the opinions provided by health consultants are not binding on the parties and not always followed by the arbitrator.

In New Jersey, approximately 55,000 arbitration applications are filed in a year but only 30 per cent make it to a hearing. The costs of the proceedings are apportioned by the arbitrator and the award may include legal fees for a successful claimant. Many hearings are completed in 30 minutes and decisions are released within 45 days. Once a decision is made, there is a limited right to appeal the arbitrator's ruling in the New Jersey Superior Court.

New York

New York has had a privately delivered no-fault auto insurance system since 1974. In New York, if a no-fault claim is submitted to an insurance company and the insurer does not respond within 30 days, the claim is deemed to be denied. When denied benefits, claimants may take the insurer to court or file with the American Arbitration Association (AAA), a not-for-profit organization with a long history and experience in the field of alternative dispute resolution.

For approximately 40 years, the AAA has administered the program for arbitration of no-fault disputes in New York on behalf of the New York State Department of Financial Services. Arbitrators are nominated by an advisory committee made up of lawyers, insurers and government officials and appointed by the New York State Superintendent of Insurance. Appointments are for one year and must be renewed annually.

A request for arbitration goes through two phases. The first phase is conciliation, where each party submits all their evidence to a conciliator. After receiving notice from the AAA of a new request for arbitration and a copy of the papers from the applicant, the insurance company has 30 days to present its own evidence and the basis for denial of the claim.

Once the documents have been received, there is a conciliation period of up to 90 days, during which the conciliator is a conduit for offers and counter-offers between the parties. The parties can choose to participate in writing, by telephone or in person. Conciliation is not comparable to mediation but only an administrative process to help parties settle. There are approximately 150,000 arbitration applications filed in a year and slightly less than 50 per cent of disputes are settled at the conciliation stage.

Arbitration requests filed directly by the injured person — including claims for lost earnings — are given expedited, priority handling. Claims brought directly by the injured person constituted only two and a half per cent of the filings in 2008. The other 97.5 per cent of the filings were made by health service providers who have obtained an assignment of benefits from the injured person in payment for their services. A case qualifying for special expedited arbitration will be scheduled within 30 days from the day it is referred to arbitration.

In New York, the applicant pays a \$40 fee, which covers the conciliation and arbitration. Insurers are assessed annually for the cost of the system based on the number of cases that go through conciliation and arbitration. In 2012, the cost per case was approximately \$350. Hearings are typically 15 to 45 minutes long, and only the more complex cases will go longer.

The usual deadline in New York for requesting no-fault arbitration is six years from the date of the denial of claim.

Any party to arbitration may appeal an arbitrator's decision by requesting the arbitration award be vacated or modified by a master arbitrator.

Minnesota

Minnesota has had a privately delivered no-fault auto insurance system since 1975. The American Arbitration Association (AAA) also administers Minnesota's arbitration program of no-fault disputes.

If a claim is \$10,000 or less and benefits have been denied, an insurer is required to inform a claimant of the right to demand arbitration. For claims over \$10,000, an insurer must advise the claimant whether or not it is willing to participate in arbitration. However, a claimant can waive part of the claim to bring the amount under \$10,000 and, as a result, make arbitration mandatory for the insurer. In Minnesota, if a no-fault claim is submitted to an insurance company and the insurer does not respond within 30 days, the claim is deemed to be denied. Following a denial of benefits, claimants also have the option of taking the insurer to court instead of filing for arbitration.

To select an arbitrator, the AAA sends each party an identical list of four names. Each party can cross out one name objected to and number the remaining names in order of preference. An arbitrator is assigned based on the responses from the parties.

The voluntary exchange of information is encouraged. However, upon application and good cause shown by any party, the arbitrator may permit any discovery allowable under the Minnesota Rules of Civil Procedure for the District Courts. Any medical examination for which the respondent can establish good cause shall be completed within 90 days following the commencement of the case, unless extended by the arbitrator for good cause.

The initial fee is \$35 for a claimant and \$130 for an insurer. The cost of arbitration is \$300. Generally, each side pays its own expenses. An arbitrator does, however, have the discretion to direct a party or parties to pay expenses as part of an award. Hearings typically last from 30 minutes to one hour, but may go on longer in complex cases.

Workplace Safety and Insurance Board (Ontario)

Both a worker and an employer can dispute a WSIB decision regarding entitlement to benefits. The time limit for appealing a decision is 30 days for decisions about return to work or work reintegration, and six months for all other decisions.

The first step involves the opportunity for reconsideration by the Board decision-maker including any new information provided by the parties and any new issues that are raised. If the decision is not changed, the decision-maker refers the dispute to the WSIB's Appeals Services Division.

Upon entering Appeals Services, the objecting party is given the opportunity to choose the 60-day decision option, which is commonly used for straightforward cases. This option involves a paper review. A decision is made within 60 days based on information contained in the claim file and any additional information submitted by the parties in writing.

All other cases are referred to an appeals resolution officer. If the parties agree at this point, the case can be resolved on the basis of submissions alone. The parties are ordinarily given 21 days to make submissions. Once submissions are received, the case goes to the resolution stage for a final outcome. Decisions are provided within 30 days.

If one or both parties wish to submit further evidence, the case goes from the review stage to the enquiry stage. Once the additional evidence and submissions are received, the case goes to the resolution stage for a final outcome. A case that is more complicated and requires an in-person hearing goes to the scheduling and hearing stages before a resolution can be reached. Oral hearings are provided within 90 days and decisions are issued within 30 days of a hearing. Workers are represented by lawyers, paralegals, union representatives or a worker advisor. A hearing will typically last from several hours to an entire day.

In recent years, the WSIB had developed a backlog of approximately 4,500 unassigned cases resulting in a six-month wait time for assignment of a case to an appeals resolution officer. A number of reforms were introduced, including more robust reconsideration process, by front-line decision makers and improvement of the resolution timelines of appeal-ready cases.

The Workplace Safety and Insurance Appeals Tribunal (WSIAT) is the final level of appeal to which workers and employers may bring disputes concerning workplace safety and insurance matters in Ontario. The Appeals Tribunal is separate from and independent of the WSIB. Decisions are made by adjudicators who are Order-in-Council appointments. There is a six-month time limit from the time of the final WSIB decision to appeal to WSIAT. Section 126 of the Workplace Safety and Insurance Act requires the Appeals Tribunal to apply WSIB policy, which is usually sent with the case, when making a decision. If the Appeals Tribunal, in a particular case, concludes that a WSIB policy is inconsistent with or not authorized by the Act, or does not apply to the case, the Tribunal does not make a decision until it refers the policy to the Board for its review and direction.

There is an optional mediation step, if the circumstances warrant it and both parties agree. Decisions of the WSIAT are made by a single vice-chair or a three-person panel. Appeals to the WSIAT often include an oral hearing, but may be dealt with through written submissions alone. Most decisions are issued within 120 days of completing a hearing.

In rare circumstances, decisions of the WSIAT may be judicially reviewed by the Ontario Superior Court of Justice, Divisional Court.

CPP Disability

An individual who is denied a Canada Pension Plan (CPP) disability benefit may request a reconsideration of the decision. Service Canada staff who were not involved in making the original decision will review the application, as well as any new information provided. If the original decision is not reversed through reconsideration, the individual can appeal to the Social Security Tribunal (SST).

The SST was created on April 1, 2013 and hears appeals for CPP decisions, as well as for Employment Insurance and Old Age Security decisions.

There are two levels of appeals. CPP appeals to the SST start at the General Division, Income Security Division. At this level of appeal, the applicant can submit additional evidence to support the appeal. An SST tribunal member reviews the file and any other information provided, and decides if the appeal should continue or be dismissed.

Decisions to summarily dismiss can be appealed to the Appeal Division. There is a 90-day time limit for appeals to the Appeal Division. A tribunal member will decide whether the appeal will be written or oral.

Appendix B — List of Stakeholder Submissions

The Advocates' Society
Allstate Insurance Company of Canada
Aviva Canada
Canadian Association of Direct Relationship Insurers (CADRI)
Canadian Centre of Excellence in Injury Law
Canadian Defence Lawyers
The Co-operators Group Limited
County and District Law Presidents' Association
Desjardins General Insurance Group
Economical Mutual Insurance
Fair Association of Victims for Accident Insurance Reform (FAIR)
Eric K. Grossman
Insurance Brokers Association of Ontario (IBAO)
Insurance Bureau of Canada (IBC)
Intact Financial Corporation
Little Morello Vettese Segreto LLP
Ontario Bar Association
Ontario Mutual Insurance Association (OMIA)
Ontario Psychological Association
Ontario Rehab Alliance
Ontario Trial Lawyers Association (OTLA)
State Farm Mutual Automobile Insurance Company
TD Insurance
Toronto Lawyers Association