RESPONSE TO THE HONOURABLE JUSTICE CUNNINGHAM'S REQUEST FOR SUBMISSIONS REGARDING ONTARIO AUTO INSURANCE DISPUTE RESOLUTION SYSTEM REFORM

Table of Contents

Introduction

The following submissions have been prepared by Intact Financial Corporation ("Intact"), in response to The Honourable Justice Cunningham's request for stakeholder input regarding reform to the Ontario Auto Insurance Dispute Resolution System ("DRS Reform") in respect of Statutory Accident Benefits ("SABs") disputes before the Financial Services Commission of Ontario ("FSCO").

Intact is the largest provider of auto insurance in the country and in the province of Ontario through its insurance affiliates Intact Insurance, belairdirect, Grey Power, Novex and Jevco.

The guiding principle of these submissions is to make auto insurance more affordable to Ontario drivers by improving efficiency, and increasing procedural fairness for all stakeholders by expediting the dispute resolution system ("DRS") process.

What follows is an identification of issues in the DRS process that impede the fair and timely administration of justice; create delays; increase its complexity; and generate unnecessary costs. This paper proposes solutions to increase the efficiency of the system and reduce excessive administrative stumbling blocks. More particularly, we propose early and greater documentary disclosure and reforms to the overall FSCO mediation and pre-arbitration hearing process.

Our submissions include both direct and indirect changes that will affect the DRS process, and would require amendments to the *Insurance Act*, R.S.O. 1990, c. I.8 (the "*Insurance Act*") *Statutory Accident Benefits Schedule – Effective September 1, 2010,* O. Reg. 34/10 (the "Schedule"), the *Dispute Resolution Practice Code* ("DRPC") and other SABs related legislation.

Executive Summary

Highlights of Intact's submissions and recommendations are as follows:

- Introducing regulations that allow only FSCO licensed treatment facilities to submit Treatment and Assessment Plans and expenses to Insurers (Section 1(a)).

- Clarifying and strengthening the purpose of FSCO Guidelines and encouraging FSCO to issue Rules of Interpretation regarding often disputed issues to promote consistency, fairness, and compliance with legislative intent (Section 1(b)).

- Expanding the timeframe and scope whereby an Examination Under Oath ("EUO") can take place, including following the suspension/termination of

benefits and during the litigation/arbitration process if one had not taken place previously (Section 1(c)).

- Mandating disclosure of standard relevant productions early on in the DRS process; with a suspension of the Insured's benefits and inability to file for FSCO mediation until compliance with documentary disclosure (Section 2(a)).

- Introducing a sufficient and extended notice period to the Insured regarding Insurer examinations, and mandating attendance with limited exception. Moreover, drafting Guidelines and/or Rules of Interpretation to clarify what objections, if any, an Insured can raise regarding Insurer examinations, including to the assessor and their in-person attendance (Section 2(b)).

- Creating a FSCO approved standardized expense form for service providers, including for housekeeping and home maintenance and attendant care, and expanding the Insurer's ability to determine whether expenses have been "incurred" within the meaning of the Schedule (Section 2(c)).

- Amending the mediation filing process to allow Insurers to stay Applications for Mediation that have been improperly commenced or pled. Further amending the mediation fee process requiring the Insured to pay the initial filing fee and only upon perfection of the Application for Mediation requiring the Insurer to pay the balance of the mediation fee (Sections 3(a) and (b)).

- Amending the legislation to eliminate "Deemed Failed" mediations if no mediation has been conducted within 60 days of receipt of the Application for Mediation (Section 3(c)).

- Issuing a Guideline re: mediation best practices to assist mediators (Section 3(d)).

- Requiring mandatory participation during mediation and imposing penalties on both Insurer and Insured for non-attendance (Section 3(e)).

- Providing mediators the ability to refer various matters directly to a preliminary issue hearing before an arbitrator to expedite the DRS process (Section 3(f)).

- Requiring all disputes following mediation to proceed through FSCO arbitration, as opposed to the current system that also allows litigation in the Courts. Simultaneously, doing away with appeals to the Director's Delegate and allowing

full appeals to be made to a judge of the Ontario Superior Court of Justice (Section 4(a)).

- Allow the Arbitration Services Group to disallow/refuse to file any Applications for Arbitration that do not properly identify all issues in dispute (Section 4(b)).

- Requiring, save and except for exceptional circumstances, mandatory in-person attendance during the pre-arbitration hearing, with penalties imposed on both the Insurer and Insured for non-attendance (Section 4(c)).

- Implementing stricter requirements and penalties on both the Insurer and Insured with respect to exchange of productions and adjournment requests (Sections 4(d) and (e)).

- Amend the DRPC so that an arbitrator is required to draw an adverse inference if a party fails to produce documents in compliance with an order or agreement and the parties attend the arbitration without said documents (Section 4(f)).

- Allowing the Insurer and Insured the ability to bring various dispositive or determinative matters directly before an arbitrator, including MIG/CAT determinations, staged accident determinations and re-payment/misrepresentation claims (Sections 4 (g), (h) and (i)).

- Introducing a MIG/CAT determination panel that includes medical experts responsible for medical conclusions during the hearing, but leaving the application of said conclusions to the Schedule and all procedural and evidentiary issues in the hands of the arbitrator (Section 4(j)).

- Streamlining the arbitration hearing itself by limiting *viva voce* evidence to shorten the hearing process (Section 4(k)).

Section (1): General Reform

(a) Treatment Facility Regulation to Combat Fraud

There have been longstanding concerns related to invoicing by various treatment facilities, including inconsistency with actual treatment and/or assessments provided to Insureds, and Insurers being “bombarded” with several Treatment and Assessment Plans simultaneously versus a comprehensive plan for various modes of treatment.

Intact acknowledges and endorses the current endeavours being taken by the Ontario Automobile Anti-Fraud Task Force, including its recommendations to licence health clinics that invoice Insurers. These initiatives, among others aimed at cracking down on fraud, are strongly supported and it is anticipated they will prove successful in alleviating the spectre of fraud and abuse of the treatment plan and assessment system currently in place.

(b) Guideline/Rules of Interpretation

Intact shares FSCO's concerns regarding the Superintendent's Guidelines having been viewed as informational and only to be "considered", which appear to be in conflict with the language found in s. 268.3 of the *Insurance Act*. As outlined in the news release issued by the Ministry of Finance on August 23, 2013, Ontario is targeting significant auto insurance rate reductions by, among other things:

> *"Reducing unexpected costs by making the Superintendent's Guidelines on accident benefits binding".*

There also remains a concern that Rules of Interpretation pursuant to section 268.2 of the *Insurance Act* have been underutilized and it is recommended that they be drafted for issues of importance to FSCO to fulfil true legislative intent. These issues include, but are not limited to: MIG, CAT, EUOs (e.g. scope), Insurer examinations (e.g. scope, timing and scheduling), and what constitutes an "accident" for the purposes of claiming SABs.

(c) Statutory Declaration and EUOs

Issue: Currently, section 33 of the Schedule allows an Insurer to obtain both a Statutory Declaration and EUO from its Insured.

Often, Insurers prefer obtaining signed statements rather than a Statutory Declaration, as the received Statutory Declarations are often void of pertinent information from which to properly assess the claim, particularly, as they appear filtered and formulaic due to completion by the Insured's representative. Further, the EUO provides a more limited scope of examination than the examination for discovery in the court system.

Some arbitrators have taken the position that an Insurer is precluded from requiring the Insured to undergo an EUO once the arbitration process has commenced. Similarly, once benefits have stopped being paid, the Insured often refuses to attend. This, in turn, disadvantages an Insurer in properly and accurately adjusting a file and knowing the case it will have to meet at arbitration.

Solution: Amend section 33 of the Schedule to allow the Insurer to take either a signed statement or Statutory Declaration from the Insured. The amendment would clearly outline the parameters of what can be asked on a signed statement (a Guideline or Rule of Interpretation may be necessary) to prevent Insured representatives from complicating the process.

Further, amend section 33 of the Schedule to allow the Insurer to conduct an EUO at any point during the Insured's accident benefits claim (including during litigation and regardless of whether benefits are being paid). This will provide flexibility to the Insurer to choose when it should conduct its EUO, without worry that it will lose its right once the DRS process has been commenced.

Failure to attend the EUO prior to mediation being commenced would result in the Insured's inability to file an Application for Mediation, until s/he has attended the examination. A Stay of Proceeding Form (discussed in detail below in the Documentary Disclosure Section) could be filed by the Insurer in the event the Insured did not attend the EUO prior to the Application for Mediation being filed.

The limitation period for disputing the benefit would continue during the "stay period". Interest would also be suspended during the "stay period". Finally, Insurer examinations would still be allowed to proceed during this "stay period" to allow the Insurer to continue to assess medical entitlement on an ongoing basis.

Failure to attend the EUO during the DRS process could result in a dismissal of the Insured's claim (much like when a plaintiff fails to attend his/her examination for discovery in a court proceeding).

Section (2): Pre-Mediation Reform

(a) Documentary Disclosure

Issue: Insurers have noticed an increasing hesitancy by Insureds to provide customary and pertinent documentation until very late in the DRS process. Lack of early and relevant documentary disclosure hinders both parties from accurately addressing the merits of the claim, including specific entitlement to benefits. This unnecessary delay further increases the legal costs and interest exposure to Insurers, particularly as mediations are being failed and arbitrations adjourned due to documentary production issues.

Finally, lack of documentary disclosure requirements creates a system susceptible to abuse, as Insurers are unable to obtain vital information/documentation from which to assess possible misrepresentation and/or fraudulent claims.

Solution: Mandate early production by Insureds of customary documentation relating to the various available benefits being claimed. Make production of these documents mandatory prior to an Insured being able to file an Application for Mediation. Failure to produce the documents would allow the Insurer to stay any Application for Mediation submitted and thereby suspend interest. The limitation period for disputing the benefit, however, would continue to be in effect.

Naturally, a grace period for production of these mandatory documents would be necessary following an application for any given benefit. However, once the grace period lapses (and assuming the requests are made by the Insurer), production of the documents would be mandatory in order to mediate the disputed benefit.

A new DRPC form (Stay of Proceeding Form) could be created, which an Insurer would have the option to file with FSCO in the event the mandatory productions were not produced prior to the Application for Mediation being filed. If the Applicant takes issue with his/her production requirements and/or a stay of the claim, this can be addressed by FSCO prior to any other step in the DRS process.

It should be legislated, however, that Insurer examinations are not affected by any "Stay of Proceeding" and are permitted during the stay period, thereby enabling an Insurer to assess and determine ongoing entitlement to benefits.

It is recommended that mandatory production be a "bright line" test. Incorporation of a "reasonable explanation" for non-production of mandatory documents would likely result in many disputes. Given that the Insured has two years from the date of denial to mediate a benefit, there is ample time for compliance with expected customary production requests.

Examples of mandatory productions include:

- **IRBs:** Prior year's income tax return/notice of assessment, employment file(s), pay stubs, STD/LTD file (if any), EI file, CPP Disability file (if any), Statements of Business or Professional Activities, etc.

- **HK/AC/CG:** OCF-6s, contact information of service providers, Statutory Declaration from the Insured.

- **NEBs:** Statutory Declaration from the Insured re: ADLs (in conjunction with the Activities of Daily Living form – OCF-12)

- **Med/Rehab:** Family physician/treating physicians CNRs (one year pre-accident), First medical record post-accident, Hospital/Ambulance records (if applicable), Treatment facility records (including sign-in sheets).

(b) Insurer Examinations

Issue: Insureds are raising issues regarding improper notice and scheduling of Insurer examinations, which at times is due to lack of effective communication between the parties.

Insureds have also refused to attend Insurer examinations for a number of reasons including requiring the curriculum vitae of the assessors; an inconvenient location; the types of questions to be addressed at the assessment; translator issues (i.e. accreditation); chaperone issues; and requiring videotaping of the assessment. These concerns impede timely and cooperative engagement in the process.

The result is that Insurers are suspending benefits for non-attendance and Insureds are disputing the suspension. Insurers are also taking the position that Insureds cannot mediate benefits due to non-attendance at Insurer examinations.

Solution: To address and alleviate the notice issue, legislate a sufficient time frame (e.g. 30 days) of advance notice an Insurer can give requiring the Insured to attend the Insurer examination, save for exceptional delineated circumstances (e.g. a death in the family).

If the Insured fails to attend an assessment that is scheduled more than the legislated time frame (e.g. 30 days) an Insurer can then file the aforementioned FSCO Stay of Proceeding Form, thereby precluding any Application for Mediation being filed by the Insured. The stay of proceeding would only be lifted upon compliance with the request to attend the Insurer examination.

Again, the limitation period for disputing any benefit would continue to run, and any interest found owing would be suspended throughout the "stay period". Further, Insurer examinations would still be permitted to take place during this time, in light of the Insurer's obligation to assess and determine ongoing entitlement to benefits.

With respect to other issues raised by Insured's to prevent their attendance at Insurer examinations, the drafting of clear and comprehensive Guidelines and/or Rules of Interpretation setting out reasonable grounds for refusal is recommended.

(c) Incurred Expenses

Issue: Insurers are receiving expenses for attendant care, caregiver and housekeeping (where applicable) with skeletal information from the Insured and a lack of evidence that these expenses have been incurred as defined by the Schedule. Consequently, Insurers are refusing to pay benefits to Insureds, who are in turn taking issue with non-payment of these benefits.

Presently, Insurers have no effective mechanism to confirm whether expenses are being incurred as claimed.

An additional concern is that while an expense form exists for the Insured to complete (the OCF-6), there is no standard expense form that the service provider is required to complete. Many forms purporting to outline performed services are repetitive and generic, giving rise to legitimacy concerns.

Solution: Legislate the ability for Insurers to obtain signed statements from service providers to confirm that expenses submitted by Insureds have been incurred.

Non-compliance/non-cooperation by services provider(s) would result in a suspension of benefits (with no interest accruing from the date of suspension) and a deemed admission that expenses were not incurred as defined in the Schedule.

Non-compliance/non-cooperation by services provider(s) would also preclude the Insured from applying for mediation. The same Stay of Proceeding Form noted above could be used by the Insurer in the event an Application for Mediation was filed after the service provider(s) had failed to comply and/or cooperate in providing a signed statement.

Also, it is recommended that FSCO prepare a standardized form for service providers to include details such as: employment status, dates, times, specific activities, payment and form of payment and/or understanding of their promise of payment. A Guideline could be prepared outlining in detail how the form should be completed including providing examples of properly and improperly completed forms.

Failure to complete this new standardized form completely would also allow the Insurer to deem the expenses as not having been incurred.

Section (3): Mediation Reform

(a) Commencing Mediation

Issue: The current mediation model requires Insurers to pay a $500.00 fee to FSCO upon FSCO's receipt of an Application for Mediation. Under the proposed reforms, Insurers would have the ability to stay Applications for Mediations if there was non-compliance with pre-mediation requirements re: documentary disclosure, Insurer examinations and incurred expenses. Consequently, requiring an Insurer to still pay the $500.00 fee in these instances would be inequitable.

Solution: Under the new reforms, the Insured would be responsible to pay FSCO a $100.00 fee to file the Application for Mediation (like it does for arbitrations). This filing fee would become a disbursement for which the Insured could seek reimbursement from the Insurer in the event of settlement or by Arbitral Order.

Provided an Application for Mediation is filed without issue, and is deemed "perfected", the Insurer would then pay FSCO the balance owing (i.e. $400.00). If there were imperfections and the Application for Mediation was stayed by the Insurer, the Insurer would not be obligated to pay the balance owing until the Application for Mediation was perfected.

If the Application for Mediation was never perfected and the claim was extinguished due to limitation period issues, then the Insured would be out-of-pocket for the filing fee. Neither the Insured nor Insurer, however, would be out-of-pocket for the entire $500.00 mediation. Requiring either the Insured or Insurer to pay FSCO $500.00 when no mediation ultimately takes place would be unfair.

(b) Improperly Prepared Applications for Mediation

Issue: Insurers often receive Applications for Mediations where the Insured has "lumped" all medical and rehabilitation benefits in dispute without delineation or specification. In essence, the Insured is seeking to dispute the account balance of a health clinic s/he has attended. Similarly, Insurers often receive Applications for Mediations that have unclearly or incorrectly listed disputes relating to specified benefits and/or attendant care benefits.

In these instances, Insurers are unable to ascertain the legitimacy and merit of the disputes and cannot properly and thoroughly respond to the Application for Mediation.

Solution: Require the Mediation Services Group to disallow/refuse to file any Applications for Mediation that do not properly identify and specify particular claims in dispute

(c) Deemed Failed Mediations

Issue: Due to fairly recent case law, mediations are now deemed failed if not completed within 60 days following receipt of the Application for Mediation by FSCO. Matters are being pushed through to arbitration or the Court without adequate issue identification, relevant documentary disclosure, or meaningful settlement discussions. Moreover, Insurers are burdened with the additional cost of paying for arbitrations ($3,000.00/arbitration) for matters that potentially could have resolved at an earlier stage, including at mediation.

Solution: Amend the legislation to eliminate deemed failed mediations after 60 days. To address the concern/desire of conducting timely mediations, a more reasonable time frame for mediation to have taken place is recommended.

This amendment would foster greater mediations to take place with a greater likelihood of early resolution of claims, as well as decreasing administrative and Insurer costs in forcing claims prematurely through the system.

(d) Mediator Best Practices

Issue: Mediators occasionally are more concerned about achieving settlement at any cost rather than listening to and discussing the concerns/positions of both Insurer and Insured. Unwarranted pressure is often put on the parties to resolve, even if there are legitimate issues in dispute that need to be further explored.

Solution: Draft Guidelines outlining best practices for FSCO mediators to follow, with an emphasis on meaningful dialogue between the parties as opposed to pressure for settlement.

(e) Mediation Attendance/Participation

Issue: Presently, Insureds often do not participate directly in mediation when represented. They are either in the representative's office, on the telephone or available by telephone, or otherwise only accessible by their representative. Insurers often question whether the Insured is, in fact, "in attendance" or aware of the opportunities afforded by mediation.

The inability for both the Insurer and mediator to speak directly to the Insured during mediation restricts the parties' abilities to enter into meaningful settlement discussions. While information is disseminated through the Insured's representative, there is a "disconnect" in the process when the Insurer and mediator are unable to see, hear, or directly communicate with the actual Insured at the centre of the dispute. Further, any "without prejudice" discussions directly involving the Insured during mediation could potentially highlight other issues not raised as part of the mediation.

Solution: At a minimum, mandate participation by the Insured at the mediation teleconference. Both the Insurer and the mediator ought to have the opportunity to address and communicate directly with the Insured. This would ensure that the Insured has an understanding of the process, his/her claim as presented, as well as the Insurer's concerns and position with respect to what is in dispute as well as the overall claim.

A further step would be to require mandatory in-person attendance at mediation stage. In person mediations require more effort by virtue of travel and face to face encounter and dialogue, often leading to a more legitimate and fruitful process. Alternatively, the mediation could proceed

by way of video conferencing, technology permitting, to address issues of mobility and travel.

Penalties should also be imposed on both Insurers and Insureds for non-attendance, absent exceptional circumstances.

- If the Insured fails to attend = suspension of interest until the mediation takes place and the re-scheduled mediation is peremptory on the Insured, with failure to attend resulting in automatic dismissal of the claim.

- If the Insurer fails to attend = costs consequence at the discretion of the mediator, but no greater than $500.00. Moreover, the re-scheduled mediation is peremptory on the Insurer, with failure to attend resulting in the mediation being failed. The non-attendance could also be considered as a basis for a special award against the Insurer.

(f) Increased Mediator Powers

Issue: Mediators lack power to make orders/rulings during the mediation process. One or both parties potentially can ignore the mediator and fail the mediation without repercussion, thereby wasting an opportunity to further the mutual understanding of the claim. This neither promotes nor fosters settlement discussion.

Solution: Expand the Mediator's scope of powers. If the Insurer and Insured are unable to resolve the matter at mediation then allow the Mediator to refer various determinative issues directly to a preliminary arbitration hearing (e.g. MIG/CAT determinations, whether an incident is an "accident" as defined in the Schedule, re-payment matters or staged accident matters).

Note: This could be an alternative mechanism to fast track various disputes to a hearing, in addition to, or in lieu of, the mechanism proposed below regarding allowing Insurers to commence various disputes without first mediating.

Section (4): Arbitration Reform

(a) Proceeding via FSCO Arbitration or the Courts

Issue: Presently, after mediation has failed, an Insured can proceed with his/her dispute either through FSCO Arbitration or Court Litigation.

If the former is chosen, the matter potentially proceeds to arbitration at FSCO and if appealed goes to the FSCO Director's Delegate. Parties can then seek judicial review (with leave) from the Divisional Court before appealing further to the Court of Appeal (again, with leave).

If the latter is chosen, the matter potentially proceeds to trial and if appealed goes before the Court of Appeal (unless the judgment is for less than $50,000.00, then the appeal goes to the Divisional Court).

Intact agrees with the Insurance Bureau of Canada's ("IBC") Submissions for Proposed Reform to FSCO ADR Process – September 20, 2013, that having same issues in dispute routed to two different, non-overlapping jurisdictions creates confusion.

Intact also agrees with the IBC's submission that there should be one appeal route for all SABs disputes. However, Intact proposes an alternative to the IBC's proposal with respect to restructuring the dispute and appeal route process.

Solution: Amend the *Insurance Act,* Schedule and DRPC and eliminate the Insured's ability to initiate a court proceeding following a failed mediation, thereby requiring all matters to proceed first through FSCO arbitration. At the same time, amend the *Insurance Act*, Schedule and DRPC to allow a full appeal right to a judge of the Superior Court of Justice, with leave to appeal available to the Court of Appeal if the parties so desire.

Theoretically, the above would do the following:

- Simplify the post-mediation process, thereby making it easier for an Insured to proceed with his/her claim;
- Eliminate any inherent bias that may exist. Currently, there is potential for FSCO arbitrators to unwittingly favour Insureds to foster an overall preference toward arbitration versus litigation. Eliminating choice in jurisdiction not only minimizes potential bias, but creates consistency in decision making by specialized and informed arbitrators.

- Temper any bias that may remain, because full appeal rights will exist before a judge of the Superior Court of Justice.
- Create binding authority from rulings of Superior Court Justices and the Court of Appeal. This would create one source of consistent and identifiable appellate jurisprudence and eliminate the present concern that arbitrators do not always follow rulings rendered by the Director's Delegates.
- Stop the process of having accident benefits disputes dragged along with Tort disputes in the Court system.

Along with these reforms, it would have to be stipulated that any new Applications for Mediation filed during an ongoing arbitration dispute would not automatically be rolled into ongoing arbitration.

The Insurer would retain the right to review the Application for Mediation to ensure that it was prepared properly. If it was not prepared properly, the Insurer would still be allowed to stay the mediation by filing the FSCO Stay of Proceeding Form.

If the Application for Mediation was prepared properly, then it would be at the discretion of the Insurer whether to roll the matter into the existing arbitration or require the issue(s) to proceed separately. This decision should be at the Insurer's sole discretion. The Insurer would take into consideration factors such as whether the issues overlap and how early the parties were in the existing arbitration process.

The above procedures would prevent Insureds from circumventing the pre-mediation requirements discussed above or by using a new Application for Mediation as grounds for adjourning an arbitration matter, close in time to its hearing date.

Insurers would carefully weigh the decision not to roll the new mediation into the existing arbitration, as it would cost the Insurer $3,000.00 (separate arbitration fee) to dispute the matters separately.

(b) Improperly Prepared Applications for Arbitration

Issue: Please refer to section 3(b) above regarding improperly prepared Applications for Mediation. The same issue applies to Applications for Arbitrations.

Solution: Require the Arbitration Services Group to disallow/refuse to file any Applications for Arbitration that do not properly identify all issues in dispute

(i.e. refuse to register that a properly completed Application for Arbitration was received until there is compliance).

(c) Pre-Arbitration Hearing Attendance/Participation

Issue: The current pre-arbitration hearing process provides Insurers and Insureds too much flexibility in permitting hearings to be conducted via teleconference. As noted previously, in-person attendance provides a better forum for free flowing dialogue and understanding, conducive for resolution and offsets the impact of any inconveniences associated with in-person attendance, including travel time.

Moreover, under the current pre-arbitration hearing process, the penalty for non-attendance by either party, in the absence of a legitimate explanation, is inconsistent and overall lacking.

Solution: Mandate, in all but the most exceptional circumstances, that pre-arbitration hearings proceed in person. Location of the party, alone, is insufficient to have the hearing proceed via teleconference.

Further, in the event of non-attendance, and in the absence of exceptional circumstances, the following penalties are suggested:

- If the Insured fails to attend = suspension of interest until the pre-hearing takes place and the re-scheduled pre-hearing is peremptory on the Insured, with failure to attend resulting in automatic dismissal of the claim.

- If the Insurer fails to attend = costs consequence at the discretion of the arbitrator, but no greater than $500.00 and the re-scheduled pre-hearing is peremptory on the Insurer, with failure to attend resulting in the striking of the Insurer's response and the Insured obtaining default judgment on his/her claim.

Intact also commends FSCO for having responded to the significant increase in the number of arbitration applications being filed at FSCO. Intact supports the recently announced decision by the Dispute Resolution Service Branch to increase the number of available pre-hearing slots each day from two (2) to three (3), effective September 2014, by reducing the pre-hearing time from 120 minutes to 90 minutes. This measure will alleviate the inordinate delay parties are now facing in scheduling pre-hearings.

(d) Production Requests During the Arbitration Process

Issue: Far too often Insurers and Insureds wait until the doorstep of the hearing to raise complaints regarding lack of documentary disclosure. Parties are left dealing with last minute motion requests for productions or an adjournment requests due to lack of productions.

Solution: Require the parties to agree to a certain date, between the pre-arbitration hearing and the hearing itself, for the purposes of a teleconference with the pre-arbitration hearing arbitrator to deal with productions issues and/or other issues necessary for the arbitration. The pre-arbitration hearing arbitrator can listen to submissions made by the parties and make appropriate orders in a timely manner.

If the parties make no requests for productions during this teleconference, they are precluded from making any motions for productions and are denied the right to seek an adjournment due to a production issue, absent exception circumstances (e.g. being served with last minute productions that reveal further relevant productions).

(e) Adjournments

Issue: Both Insurers and Insureds are requesting too many adjournments of hearing dates and too many adjournments are being granted by arbitrators. This creates additional delays in the DRS process and denies the parties the ability to have a timely hearing. Delays further increase the costs of both parties, the potential interest exposure to the Insurer, and can lead to potential degradation of evidence.

Solution: Absent exceptional circumstances, mandatory penalties should be imposed following the second adjournment request made by the Insurer or Insured, if the adjournment request is opposed. For example:

- Penalty to the Insured = stay of interest following second adjournment request and dismissal of claim following third adjournment request and non-attendance at hearing.

- Penalty to the Insurer = costs penalty following second adjournment request and striking out of Response following third adjournment request and non-attendance at hearing.

This reform should be considered ***only if*** all other proposed reforms in these submissions are adopted. The harsh adjournment penalties are

justifiable only if the other measures designed to increase efficiency, reduce excessive administrative stumbling blocks, and facilitate early and greater documentary disclosure are implemented.

(f) Adverse Inference for Failure to Provide Productions

Issue: Parties often fail to comply with orders issued by pre-hearing arbitrators. The lack of documentary disclosure in accordance with arbitral Orders delays the parties' ability to discuss settlement and creates an evidentiary vacuum during the arbitration hearing.

Solution: The current DRPC allows (but does not require) an arbitrator to draw an adverse inference if a party fails to comply with a time requirement of the Rules, order or agreement or fails to produce documents in compliance with an order or agreement. Intact recommends amending the DRPC so that an arbitrator is required to draw an adverse inference if a party fails to produce documents in compliance with an order or agreement and the parties attend the arbitration without said documents.

(g) Staged Accident/Re-payment/Misrepresentation Claims

Issue: Insurers presently have no efficient mechanism to seek determinations on issues such as whether Insured(s) have staged an accident, re-payment of benefits or material misrepresentation of claims. Insurers are forced to apply for mediation, fail the mediation and then seek recourse in the Courts. This is inefficient, time consuming and costly and leaves claims of questionable merit open for unnecessarily long periods of time.

Solution: Amend the DRPC to create a streamlined process for determining these types of complaints at any time during the DRS process. A process similar to the Court's summary judgment motion procedure (or Application procedure) could be arranged.

A sample process is as follows: An Insurer who has done its investigation and suspects there has been a staged accident, overpayment or material misrepresentation can claim against the Insured. The Insured is given notice of the claim and allowed an opportunity to respond. Documents to be relied upon are exchanged. A streamlined hearing can be held with limited witnesses (for the Insured: him/herself, his/her witnesses and expert re: accident reconstruction and for the Insurer: its SIU expert, witnesses and expert re: accident reconstruction).

If there was a finding in favour of the Insurer, then in the cases of staged accident and material misrepresentation, the Insured's claim is terminated. In the case of a re-payment claim, re-payment would have to be made, and failure to comply would result in termination of the Insured's claim.

If there was a finding in favour of the Insured, then costs and interest consequences would arise, and a case for special award could be made if the Insurer's position was determined to be unreasonable in the circumstances.

Note: In the staged accident context and perhaps the other contexts the recommendation would be to allow joinder of claims in situations where there were multiple claimants. Similarly, the third party Insurer could add itself to the claim and seek a determination against its own Insureds. This would eliminate duplication of claims and risk bringing the administration of justice into disrepute with inconsistent rulings.

Note 2: Time limits would have to be imposed for bringing such claims to promote efficiency and due diligence. For re-payment claims, this is already codified in the Schedule (one year prior, absent willful misrepresentation or fraud). A similar time frame could be imposed for material misrepresentation claims. For staged accident claims, a more strict time period post-accident (e.g 26 weeks following receipt of the OCF-1) could be imposed, in all but the most exceptional circumstances.

(h) MIG Determinations

Issue: Determination of whether an Insured is MIG is one of the biggest stumbling blocks in resolving disputes with MIG issues. Once a determination has been made, the Insurer and Insured are usually in a better position to resolve the claim.

Having the MIG issue decided at the hearing of all disputed issues is an inefficient means of resolving disputes. Although there are mechanisms (e.g. a preliminary issues hearing) to decide this issue at an earlier stage, Insurers and Insureds are not being proactive. This prolongs the dispute DRS process and increases both costs and expenses on both sides.

Solution: Amend the DRPC to create a streamlined process for determining MIG at any time during the DRS process. A process similar to the Court's summary judgment motion procedure (or Application procedure) could be arranged. If the matter was pre-mediation, both parties would have to agree to the process.

Also, if both parties have not agreed to this by the date of the mediation, the mediator could render a decision on whether a MIG determination hearing was necessary and refer the matter to an arbitrator. The mediator may refuse to make a MIG determination hearing order only if either party provides a reasonable explanation for why the hearing would be inappropriate at the time (e.g. awaiting critical medical documentation). The issue could again be re-visited by the pre-hearing arbitrator.

(i) CAT Determinations

Issue: Determination of whether an Insured is CAT is the biggest stumbling block in resolving disputes where this is an issue. Once a determination has been made, the Insurer and Insured can generally resolve the claim.

Having the CAT issue decided at the hearing of all disputed issues is an inefficient means of resolving disputes. Although there are mechanisms (e.g. a preliminary issues hearing) to decide this issue at an earlier stage, Insurers and Insureds are not being proactive. This prolongs the dispute DRS process and increases both costs and expenses on both sides.

Solution: Amend the DRPC to create a streamlined process for determining CAT at any time during the dispute resolution process. A process similar to the Court's summary judgment motion procedure (or Application procedure) could be arranged. If the matter was pre-mediation, both parties would have to agree to the process.

If both parties have not agreed by the time of the mediation, the mediator could render a decision on whether a CAT determination hearing was necessary and refer the matter to an arbitrator. Submissions could be made by both parties and the mediator may choose not to make a CAT determination hearing Order provided there is a reasonable explanation given by a party for why the hearing would be inappropriate at the time (e.g. awaiting critical medical documentation). The issue could again be re-visited by the pre-hearing arbitrator.

(j) MIG/CAT Determination Panels

Issue: MIG/CAT determinations are important for both Insurers and Insureds, as they determine whether Insureds have increased access to benefits/quantum of benefits.

Whether an Insured falls within the MIG or is CAT is a legal determination and within the expertise of FSCO arbitrators. However, in order to make

that legal determination, FSCO arbitrators often have to go beyond their area of expertise and make medical findings/conclusions. Potential for significant errors to be made by arbitrators exists, therefore, on issues that are of the utmost importance to both Insurers and Insureds.

Solution: The creation of a MIG/CAT determination panel comprised of an arbitrator and two medical experts. One proposal is that one of the medical experts is a physical impairment expert and the other is a mental impairment expert. An alternative proposal is that the parties choose the two most relevant medical experts. Failure to agree to the experts results in the arbitrator selecting the panel. In both instances, there should be a roster of impartial FSCO approved medical experts that can be chosen.

The medical experts would be responsible for making all medical conclusions regarding the Insured's injuries (e.g. findings of DSM IV diagnoses, findings of chronic pain or calculating WPI ratings). The arbitrator would then take these medical conclusions and apply them to the appropriate legal test. Further, the arbitrator would retain all control over the arbitration process, including procedural and evidentiary rulings.

(k) Arbitration Hearing

Issue: The intent of the FSCO arbitration process is to apply the most just, quickest and least expensive means of resolving accident benefit disputes. This used to be the case, when FSCO (and its predecessor the OIC) was first created. Arbitration hearings, however, are becoming increasingly more complex with multiple witnesses being called in a manner not unlike a civil trial. Moreover, document briefs are becoming increasingly voluminous. The result is that the arbitration process is becoming more expensive, lengthy and FSCO resources have been stretched thin.

Solution: Given the volume of productions that should already be available in the documentary record, especially if these proposed reforms are adopted, an arbitrator would have a significant basis from which to decide the issues in dispute.

In light of the above, streamlining the arbitration hearing by limiting *viva voce* evidence should be a goal. For example, limiting *viva voce* evidence to the Insured, Insurer's representative and up to 2 witnesses/experts for each side – no exceptions, would reduce the length of most arbitration hearings and force the parties to call only their key witnesses.

Granted, the parties may have concerns with the credibility/validity of the reports being submitted by the opposing party as there will be no chance to cross-examine most experts on their reports. To address this, a rule could be drafted allowing an opposing party to confirm in writing with the author of the opposing party's report that the author did indeed draft the report. The opposing party can then always attack any credibility of the report in his/her submissions.

To streamline the process even further, consideration can be given to whether factums should be filed in advance of the hearing by both parties outlining their respective opinions based on the documentary evidence. This would again limit oral submissions made by both parties during the hearing.

Conclusion

We would again like to thank The Honourable Justice Cunningham for requesting our contribution regarding reform to the Ontario Auto Insurance Dispute Resolution System.

It is our belief that the foregoing submissions will assist the Ministry of Finance, FSCO, and the government to achieve the mutually desired goal of improving efficiency, expediting the DRS process, increasing procedural fairness to both Insureds and Insurers, and making auto insurance more affordable to Ontario drivers.

Intact looks forward to receiving any feedback The Honourable Justice Cunningham may have and welcomes the opportunity to make additional submissions, if requested.