SUBMISSION

IBC response to Interim Report – Ontario Automobile Insurance Dispute Resolution System Review

I. Introduction

Insurance Bureau of Canada (IBC) appreciates the opportunity to provide comments on the interim review of the Ontario Automobile Insurance Dispute Resolution System (DRS) prepared by Justice J. Douglas Cunningham.

We commend Justice Cunningham and Mr. Murray Segal for their insightful and comprehensive recommendations to improve the DRS in Ontario. The background, history and observations in the paper highlight many of the problems that have been present in the system for many years and, in recent years, have grown to crisis proportions with the unprecedented caseloads now being processed. . The interim report lays out a framework for bold and innovate steps to overhaul the system. The comprehensive reform strategy includes numerous recommendations that we support or support with qualifications. These include:

- consolidating the mediation and arbitration process,
- moving the DRS to the private sector, albeit with the important caveat that the fees chargeable for DRS services are subject to regulation and thereby assured to remain reasonable; and
- consolidation of appeals to a single forum, for which we urge that a panel of 4 or 5 judges with SABS knowledge is created and from which a single judge can be identified to hear appeals of SABS cases.

We firmly agree with the thematic thrust of the Interim Report that extensive change is needed to achieve an affordable and stable auto insurance system for Ontario's drivers. The detail and execution of these recommendation will, of course, be critically important, as well-intended ideas often have unforeseen consequences. To this end, we are particularly mindful of the specific recommendations that we feel bear further detailed discussion.

IBC has identified the following topics as needing additional discussion and deliberation.

Mechanism for ensuring that adjudicators receive appropriate policy direction

Many of the decisions regarding disputes over issues related to the Statutory Accident Benefits Schedule (SABS) have an impact that is much broader than the individual claim at issue. This being the case, there is a need to firmly separate the regulatory and adjudicative roles that are often played by the arbitrator. It is critically important that arbitrators are not able to set policy that is contrary to the government's intentions in establishing the regulations. To this end, procedures need to be in place to ensure that adjudicators receive appropriate policy direction.

In our earlier submission we pointed out that the authority for the government to provide this direction exists pursuant to s. 268.2 and 121 (1) paragraph 10.2 of the Insurance Act. In theory, the government's access to this mechanism should leave the responsibility for making policy in the hands of regulators and rule-makers, thereby permitting full consideration to be given to the complex legal issues and policy considerations. Unfortunately, despite numerous arbitration decisions that have departed widely from original regulatory intents, government has shown little inclination to utilize this rule making authority, and the result has been to aggravate the unpredictability of the environment in which insurers need to adjust claims and proactively determine required premium levels. We recommend that the legislation mandate regulatory responsibility to actively monitor emerging issues and utilize the statutory authority to correct misinterpretations by arbitrators or other concerns.

Obligation for insurers to establish a formal internal-review process

The report suggests that a more formal process be established for insurers to provide a second review of any denial and put in place a protocol to meet with the claimant before dispute resolution is initiated.

We would like to point out that many insurers already have such protocols in place. Insurers welcome the opportunity to meet directly with the claimant, particularly as experience has shown that in-person meetings often lead to better and more timely resolutions. However, it will be important that any new process requirements are productive, as opposed to simply adding an extra layer onto existing processes. Consequently, we suggest that the requirement on insurers should be limited to informing claimants of the existence of second review process within the company and delivering the process to claimants who have requested it.

Allowing health care providers to initiate a dispute for bill collection without the claimant

The report suggests that health care providers be permitted to initiate disputes against insurers without the claimant for the purpose of bill collection. There is also a suggestion that providers incur some of the costs as opposed to the current system they can indirectly access at no cost.

This is a controversial suggestion because use of the current system for the purpose of bill collection has been a significant contributor to the backlogs. This is why in our first submission to the DRS review; we expressed the view that other mechanisms, such as small claims court, may be more appropriate for this purpose. However, as the Interim Report suggests that this view is not likely to prevail in the final report of the Review, we recommend that certain conditions should apply, thus:

- There should be a separate fast-track process for dealing with disputes over billing amounts
- Provider businesses should pay the same DRS fees as are charged to insurance companies and these disputes should be subject to the "loser pays costs" rule
- Further to this, claimants must have formal role in these processes, including in-person attendance at the proceedings. Only the claimant can give the evidentiary basis for the claimed benefit in the full context of all services, history and impairment. But the claimant's participation is important for other reasons. Of course, there is the legal question of contractual privity. But in a non-legal sense, we need to be sensitive to the fact that the claimant is the person whose benefits are to be expended, partially or fully depleting available limits. It is inherently inappropriate to engage a process that expends the person's insurance protection without their involvement. Furthermore, the person's involvement is necessary to prevent fraudulent claims for payment for services not rendered, and also because the outcome will potentially result in a claimants' personal liability to pay a provider (for example, in situations where the services were provided without prior approval from the insurer).

Expert medical panel

We continue to see value in providing arbitrators and other participants with the benefit of a neutral expert medical resource, as to the generally accepted medical norms for treatment and outcomes of a particular injury condition. Such a resource, drawn from a roster of medical experts, would carry out a review of concise supporting documentation on a case and provide context for the evaluation of the credibility of a diagnosis and impairment described in the documentation as well as the appropriateness of proposed treatment options within the context of current medical knowledge.

At the same time, we recognize the concerns that some insurers have raised about this concept. Particular concerns that have been raised relate to the difficulty of identifying medical experts who are seen as truly "neutral", and, over time, the potential to add cost, complexity and delay to the process.

This feature should be no more than an opportunity to set the context for evaluation of a dispute. It is an aid to adjudication, but not more.

The panel members must have professional credibility to add value to ensure that injury evaluation is based on science.

Importantly, the engaged medical experts would become a valuable resource for identification of patterns of behavior in the insurance system that call for regulatory attention.

Possible elimination of lump sum payments

The report advocates for extending the one-year prohibition on lump sum settlements. This proposal has invoked mixed feelings among insurers because it has the potential to remove incentives to settle out of the system. As noted in the report, the ability to close files adds to predictability and certainty for insurers. On the other hand, as one insurer recently noted, "Regretfully, the system encourages an opportunistic approach for many clinics to make money from quick cash. While it may seem far more economical for the industry to settle these files for what would be considered small amounts, it fosters this opportunistic approach, ultimately flooding of the system with small disputes."

Clearly, there needs to be balance between permitting an environment that encourages claims to be made for the sole purpose of winning a cash award (which is what existed prior to the introduction of the current rule on lump sum payments in 2003) and having a rule that leaves no incentive for claimants to close their files. We believe that balance has been struck with the current one-year prohibition on lump sum settlements for SABS claims, and that either eliminating it or extending it will only serve to increase the unpredictability of claims management and outcomes.

Compress the timelines for disputes and impose penalties

We agree with the Interim Report's judgment that the current system is taking far too long to render a decision and add our view that negative consequences of this system dysfunction are borne by injury claimants, insurers, and the driving public. To this point, it is also disheartening that past procedural initiatives to make the process more expeditious have been ineffectual by virtue of FSCO's lack of enforcement.

Based on our members' extensive experience with the DRS, we recommend the following procedural changes to help address the pervasive culture of delay in the system:

- Mandate early production by the claimant of customary documentation relating to the various benefits being claimed, and include the sanction that the claimant is barred from initiating or continuing a dispute if this documentation has not been produced.
- Mandate that the claimant is not able to commence a dispute unless they have complied with and/or attend an Insurer Examination with respect to the treatment plan at issue and/or Examination Under Oath, if requested

- Permit suspension of accrual of interest on outstanding benefits where the claimant fails to comply with these mandated procedures.
- Enable insurers to obtain signed statements from service providers to confirm that expenses submitted by a claimant have been incurred

Decisions that set precedent bring certainty to the system

The report indicates that there is merit in having decisions that set precedent in that they offer greater certainty. Although we understand the logic of this view, we cannot agree that greater certainty is achieved by enabling arbitrators to set policy, which effectively what setting precedent via arbitration decisions implies. There are many examples where arbitration decisions have set precedents that have resulted in a destabilizing effect on the entire insurance system. We have provided examples of these types of decisions in our previous submission.

Earlier in this submission, we cited FSCO's historical failure to exercise the existing authority to provide policy direction to arbitrators when decisions are at odds with the regulation's policy intent. While this practice continues, it will be critically important to the stability of the auto insurance system that arbitration decisions are not accorded precedential value.

No requirement for in-person attendance for mediation

The report suggests that in-person attendance is not always needed. We disagree with any suggestion that anything other than in person attendance is acceptable in most cases. Insurers' long experience with claims adjudication and settlement satisfactory to the parties provides persuasive evidence that claimants need to be central to the process in almost all cases. When disputes arise, that experience teaches that resolution is facilitated by face-to-face meetings. Moreover, in the combined mediation-arbitration model proposed in the Interim Report and in a fast-track process that we recommend for resolving billing disputes, we believe that concerns about inconvenience to claimants or about costs and delays from requiring claimants' in-person attendance at proceedings should be largely allayed.

Overworked and under-qualified adjusters are part of the problem.

As evidenced by the volume of cases moving through the DRS, company adjusters and claims staff have heavy demands on their time. It is to be expected that all participants in the system are strained by the volume of disputes and the extraordinary inefficiency of the current system. Changes that reduce the number of cases and make the system more cost- and time-effective will go a long way to relieving this pressure.

II. Conclusion

The need for comprehensive reforms to the Financial Services Commission of Ontario's dispute resolution system is clearly understood in Justice Cunningham's interim report. The system is burdened with an unprecedented volume of cases and is in dire need of reform. As the report shows, the dispute resolution system poses significant cost implications for insurers at the same time that insurers are being held to the government-set target of reducing premiums by 15 per cent over the next two years. Reforms that reduce costs in the system cannot come soon enough and we hope action to implement DRS reform will come at the earliest opportunity. We are pleased to have this opportunity to offer feedback and look forward to meeting with you again to discuss both the interim report and this submission.