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Dear Sir/Madam:

Re: Ontario Automobile Insurance Dispute Resolution System Submissions on Interim Report

I thank Justice Cunningham for the opportunity to make submission in respect of his review. I have spent some time reviewing his interim report and wish to address a few points.

COMMENTS ON OVERVIEW IN INTERIM REPORT

The interim report seems to suggest that the complexity of the dispute resolution system has been the cause of a dramatic increase in legal representation to close to 100% in respect of DR in recent years. While there can be no doubt that there is increased complexity in the DR system, it is not clear that the increase in represented individuals is "dramatic." From the very beginning of DR at the Ontario Insurance Commission in the early 1990s, representation at arbitration was above 90%. If there has been an increase in represented claimants that is dramatic it might be at mediation. At arbitration, most claimants have availed themselves of the use of counsel from the outset.

Some time was spent analyzing the claims volume data as between the Greater Toronto Area and outside of the GTA. Reference was made to the higher settlement value outside of the GTA but the larger number of claims in the GTA. My experience suggests that there is a far higher volume of opportunistic claims generated in the GTA either through the advent of treatment facilities or legal representatives, where the claimants are really not terribly participatory in the process. Outside of the GTA, this phenomenon is not as prevalent and as a result, where claims are presented outside of the GTA they tend to be substantively more weighty.

Lastly, reference was made to the increased usage of paralegals in the system. Separately, reference was made to the advent of contingency fees in claims relating to accident benefits. Notably, the advent of paralegal to supplement lawyers generally in the province of Ontario was

because certain processes became prohibitively expensive for lawyers to provide service and it was perceived that paralegals could provide competent assistance for a much more modest expense. Flat fee services for Small Claims Court, and traffic court, as well as immigration and divorce assistance are areas that come to mind. With that backdrop in mind, it must be noted that the involvement of paralegals have generally not added anything to the notion of access to justice, or justice more inexpensively: paralegals charge the same contingency percentage as a lawyer. As a result, one questions the efficacy of paralegals in the process.

COMMENTS ON INTERIM RECOMMENDATIONS

Expedited Processes for Claims under $25,000.00

As one of the early advocates for expedited processes, I obviously am very favourably inclined to this recommendation. My cautionary concern relates to the monitory threshold of this approach. Where the vast volume of abusive tactics takes place at the lower level of claims activity, there needs to be some safeguards to ensure that this expedited process does not minimize opportunities to expose the various suspect claims for what they are. Where representatives are not above deluging insurers with claims to generate economic resolution of files so insurers can avoid $3,000.00 filing fees, the concern I would wish to point out is that a $25,000.00 threshold could actually generate more abusive tactics if great care is not placed in the manner in which these expedited processes are carried out.

Medical Advisory Committee

The interim report references the historical role of designated assessment centres as providing a neutral medical opinion, and notes that the DAC was abolished due to cost concerns. The review of historical features of the accident benefit system did not go back far enough in that under the old OMPP legislation which covered the period 1990 to 1993, there was indeed a panel created by statute called the Medical & Rehabilitation Advisory Panel. Indeed, this panel was used for exactly the purpose that Justice Cunningham was envisioning in his interim report. It was not used frequently but did get some recognition by arbitrators in a limited number of FSCO cases.[1]

Proposed New Mediation/Arbitration Model

I applaud Justice Cunningham on his suggestion of bringing the clinics out from behind the curtain and force them to advance their claims directly by way of assignment from claimants, where these clinics could then can be hit with costs for advancing nefarious claims. Unfortunately, there may be some detail that needs to be thrashed out respecting this issue to a greater degree. Often times claimants seeking treatment find their way to these clinics and are told that they cannot have any treatment until they sign up with the legal representative

[1] *Richardson v Royal*, November 3, 1992; *Lee v Unifund*, September 14, 1993, *Alrawdah v Zurich*, September 24, 1993, *MacNeill v Royal*, January 10, 1994, *Beenen v Continental*, September 8, 1994, *Shelley L. P. v Royal*, dated June 23, 1995.

enmeshed within their facility. There is invariably a conflict for a legal representative to be enmeshed in such a facility and this conflict is not disclosed for the most part at the time of engagement. The documents that are signed by the claimant are not properly explained and no independent legal advice is provided. For assignments to be given validity there must be some component of independent legal advice. Indeed, there needs to be greater regulation of these clinics (which we know is not within the mandate of this review to pursue) but with a mind to ensuring that clinics are not advancing claims even by way of assignment where the claimants are blissfully unaware of what is going on.

The suggestion found at Page 31 of the interim report of extending the one year no lump out rule is certainly something that ought to be considered more fully. A review of the Michigan Personal Injury Protection (PIP) claims process might be of assistance to you in this regard. In Michigan, there is a Catastrophic Injury Claims Fund which each casualty insurer in that state pays into. Above a certain threshold of payouts on an individual claim, the insurer can claim reimbursement from the Catastrophic Injury Claims Fund. However, that insurer can only do so in respect of payments made in respect of individualized incurred past claims. There is no recourse for reimbursement for future or lump sum payouts. As a result, it is my understanding that in Michigan there really is no such things as a "cash out" out of what is otherwise unlimited medical and rehabilitation coverage.

The reality seems to be that casualty insurers have a different mindset and approach to their claims process and staffing of claims units than life and disability insurers do. Casualty claim units measure performance in part by the number of files they can close. Life and disability insurers seem to take little or no interest in closed files. They simply manage files as they come about, and have no concern about keeping a claimant on claim month to month. Life and disability insurers have captive medical experts on staff to assist their adjusters with making decisions on issues of entitlement, and refer to outside experts with the direction and assistance of their staff medical consultants. To my knowledge, there is not a single casualty insurer in this province that has a staff medical consultant. Whether it is the perception of bias, the inability to adequately capture the expense of such employees as part of file expenses, or otherwise, this is still ponderous where the type of benefits sought in both regimes are so similar. The whole notion of a system of delivery of accident benefits which may have lifelong entitlements would speak to a life and disability insurance model more so than the casualty model which otherwise focuses on individual claims from individual incidents for which early resolution and closure is a measure of success. I would assert that one must delve more deeply into the question of why it is that life and disability insurers do not cash out claims files and are quite content to leave open claims for as long as a claimant lives or until their 65th birthday when the coverage lapses in most cases. It may require a much more extensive re-tooling of mindsets to alter the current status quo.

In the context of contemplating a shift to such a model, recognition must be given to the significant procedural differences there are in place in managing a life and disability file and managing an automobile accident benefit file. In an LTD or med-pay file, there are no procedural hurdles. There is no statutory language. There is simply a non regulated contract. Accident benefit insurers are at a disadvantage in adjusting their files, relative to the disability carrier given the raft of statutory and regulatory obligations.

The cost of handling the files is monumentally higher where the SABS require (in many cases) large numbers of assessments (usually by various disciplines) in order to do due diligence in adjusting a claim. These assessments are effectively part of the good faith duty of the insurer unless a claim will be accepted in its entirety. The hurdles an AB insurer must climb through to make a decision are numerous, costly and time consuming relative to life and disability insurers. While the examples from the case law on how many hurdles there are, and how pedantic some of these decisions seem to be are numerous and unending, I can reference the most recent FSCO decision in *Augustin v Unifund* (FSCO A12-000452, November 13, 2013 decision) as but one example.

Furthermore, the case law developed through FSCO has created a fairly low bar (relative to the common law forms of extra-contractual damages) for exposure to a special award. A much higher standard is required of an auto insurer to avoid an allegation of "unreasonable" handling relative to the test for extra-contractual damages, but even then, auto insurers seem to be facing more extensive scrutiny in court than LTD insurers. This higher level of scrutiny itself means that accident benefits cases will be more expensive to administer. Thus, there is generally a strong economic reason for seeking to resolve the claim on a full and final basis. Simply put, the casualty insurer's adage "the only good file is a closed file" has much application in the accident benefit context given the fact that a very negative backward looking lense seems to be applied in scrutinizing file handling decisions of accident benefit carriers. Keeping a file open longer on a mandatory basis only allows more of these issues to potentially percolate. [2]

Lastly, the suggestion that the appeal unit at FSCO be abolished and that appeals be made from an arbitration to a single judge of the Superior Court requires some further discussion. I take no issue with this suggestion that all DR functions be removed from FSCO. Further, I take no issue with removal of appeals from the arbitration model. The appeal route proposed by Justice Cunningham is similar to that which is found in respect of appeals from priority and loss transfer disputes done in a private arbitration environment. Having been counsel on a number of such cases, it is often the case that a single judge of the Superior Court is at a distinct disadvantage in dealing with these matters on appeal. While there have been a number of well-reasoned and well-considered appeals in such circumstances, there have also been a great number of cases which the single judge was ill-equipped to address, in areas of complexity with which they had no prior experience. In such circumstances undue deference was often shown to the decision maker at first instance largely because the judge figured that the arbitrator chosen by the two parties had to know better than he or she did. This concern, together with the other practical concern pertaining to the appeal on interlocutory or preliminary issues in arbitration makes appeals to the single judge of the Superior Court problematic. I would recommend that there be a privative clause in the newly proposed system. Thus, decisions could be judicially reviewed but not appealed. If there were errors made which go to the heart of the jurisdiction of the arbitrator or pertain to pure questions of law, a judicial review to the Divisional Court would be the recourse available to the aggrieved party. It strikes me that this is a more efficient method of dealing with appeals. It also accords with the practical reality found at FSCO today which is that most appeals

[2] The writer acknowledges and credits his partner Jennifer Griffiths for articulating this last argument.

are unsuccessful and if an appeal is ultimately successful it usually is by reason of judicial review thereafter.

I once again offer my assistance to Justice Cunningham in the completion of his recommendations and I am available to the extent that there are any further questions of me or to the extent I can otherwise be available to him in the preparation of his report.

Yours very truly,

Eric K. Grossman
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