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Submissions for Proposed Reform to FSCO ADR Process

September 20, 2013

Introduction

The process by which injured Ontario auto accident victims are compensated has been the subject of nearly continuous review since 1987. In 1990 the legislature introduced a comprehensive revision of the approach. The tort damages model of compensation was greatly restricted. Very significant provision was made for extensive "no fault[1]" compensation.

As the "no fault" benefits were significantly enriched, the legislature revised the process for dealing with any benefits disputes by providing for mandatory mediation, and the option of arbitration or court for any unresolved issues. Necessarily, all such disputes go through the alternative dispute resolution (ADR) process for mediation and many cases continue into the arbitration stream. Management and administration of the mediation and arbitration functions has been reserved for the Financial Services Commission of Ontario (FSCO). A large number of disputes go into the court system after mediation.

In the following two decades we have seen a dramatic change in the system's operations – unfortunately much of the outcome is undesirable. Costs have risen, notwithstanding sequential reductions in benefit coverage. There is no evidence that injured victims are better off. Indeed, the financial data with respect to payment of disability claims suggests that disability durations have at least doubled between 1996 and 2009. The exponential increase in treatment costs has not delivered any benefit, but has become an increasing burden for premium payers. Premiums consume an inordinate part of disposable income for Ontario's motorists.

Recurring problems have led to a cycle of reform – a cycle that has repeated many times. Consistently the efforts at reform have been tempered by a desire to appease stakeholders, and a seeming reluctance to confront the design features that cause many problems. The reform process has a track record of achieving limited, transitory, relief. The cumulative effect of sequential reforms has mitigated some problems, but has not succeeded in bringing the system into stable, effective, and balanced mode.

The current trending on tort claims is a concern. The data with respect to Statutory Accident Benefits Schedule (SABS) claims is shocking. The pace of new SABS claims is approximately 62,000 per year. Based on HCAI data, it appears that there are over 9,000 health care businesses engaged in providing services to this group of claimants. That is one business (with some number of health professionals) for every seven claimants!

Some of the trend may also be attributable to fraud. Large sums of money are within easy reach of dishonest or unethical people. Much is determined by bald assertions, untested

[1] It has become common to refer to these benefits as Statutory Accident Benefits(SABS) although that term was not introduced until November 1, 1996.

by any objective benchmark. Insurers' prime responsive tools, insurer examinations, have been greatly limited and too often are given little weight.

The average cost of a medical/rehabilitation claim has climbed from $28,978 in 2005 to $50,296 in 2010. It should be noted that this coverage was reduced as part of the 2010 reforms.

The Key Determinants of SABS Performance

The SABS program is a heavily regulated scheme, marred by stupefying complexity, and additionally challenged by frequent operational changes that require retooling. The performance of the program is driven by:

- The design of the benefits package – encompassing both the extent of benefits and the procedural provisions that have an impact on entitlement determination
- The regulatory framework that governs claims activity; and
- The outcome of dispute resolution activity that signals the attitude/values to be applied to claimed entitlement and that interprets the program, frequently changing the perceived design.

A great deal of claims activity is a direct result of how users perceive the likely outcome of the dispute resolution process. Regardless of what seems appropriate at the point of claim, if the protagonists believe that a dispute resolution outcome is otherwise, that perception fuels a controversy and defines a settlement. In short order, those impressions stimulate claims, offering a roadmap to money for the multitude of opportunists that quickly exploit any observed weakness.

It is critical that the SABS dispute resolution process efficiently produce contextually appropriate outcomes, and be seen to be appropriately sensitive to the need to have a benefits system that has the confidence of the users. At this moment, the system has strayed far from this.

I. The Development and Current Status of the ADR Function of FSCO

No longer addressing necessary compensation for actual automobile accident-related injuries, the ADR has become focused on the entitlement to statutory accident benefits as a matter of right, with little regard given to reasonable needs. Although this evolution may have been unintended, it is pervasive throughout the current FSCO ADR system.

At the outset of the post-1990 regime, the expectation of the regulatory body, and the various stakeholders involved, was that few cases would actually reach the FSCO ADR stage.

Nor was it anticipated that the FSCO ADR process would be used as a source of law or evolve into a policy-making body. Rather, it was expected to apply value judgments that were aligned with the value judgments of those who drafted the applicable regulations and priced the product to be delivered.

Over the past two decades, things have turned out much differently than was ever expected at the outset. Along the way, the ADR process has created various challenges for the administration of the Ontario accident benefits scheme. In particular, the process has become overwhelmed with procedural and medical-legal complexity. Users of the system are required to wade through and understand hundreds of decisions (which may or may not be consistent) in an attempt to comprehend the particular principles of interpretation being applied. Moreover, the administrators of the regime lack the resources required to handle the rapidly increasing volume of questioned claims made.

The FSCO ADR process has not been adequate to deal with this reality. The process moved away from being an expeditious and inexpensive method of dispute resolution, which deals with occasional disputes. It has become the norm to expend a significant amount of time and resources within a process-laden system for any disagreement over injury compensation. It is now the epicentre of a product delivery system that is incapable of offering the service it was designed to provide.

As a result, the FSCO ADR process has generated instability and uncertainty in the Ontario automobile insurance scheme. Recently, this instability and uncertainty caused the system to grind to a halt due to its inability to address the relevant statutory and regulatory conditions and to apply them to the multitude of claims that have come before it.

The failure of the ADR system has shown up in court actions that decry the denial of due process caused by the system failures. Recent case law has held that statutory obligations may be dispensed with on the basis of due process concerns. Nonetheless, insurers are required to cope with the burgeoning cost of the system.

All stakeholders have increasing levels of discomfort with regard to the instability and uncertainty of the current system, whose character is largely defined by an extraordinary backlog of cases trapped in a queue. Recently, as a result of judicial condemnation, and critical comments from the Auditor General, the backlog of cases waiting for commencement of mediation has been reduced. But now the delays seem to exist at other stages. The backlog may only be relocated, not eliminated.

The present predicament is in sharp contrast to original design expectations in 1990. Many held the view that no cases would proceed to mediation for the reason that there was nothing to dispute. A significant backlog of mediation cases had built up over the past years. At one point, the backlog exceeded 30,000 cases. With assistance from outsourced mediators, it took until mid-August of this year for the backlog, which is now defined as "open files not yet assigned" to clear. Although dates have been scheduled, many cases are still waiting to be mediated. In 2013 there has been an average of 2,000 new mediation cases registered each month. Many of these will make their way to arbitration or court actions, which are also on the rise. These are telling numbers, given that the annual number of SABS claims has fluctuated between 60,000 and 70,000 in recent years[i].[2] The disproportionate number of cases that has entered formal dispute resolution proceedings is indicative of system dysfunction. Perhaps this is partly explained by the fact that there are more than 9,000 health care businesses with over 33,000 service providers that bill insurers for health care services for SABS claimants. All of this activity is in addition to medical and hospital services already provided by Ontario's public health insurance system.

Concerns about ADR are not limited to the pervasive workflow challenges. Users are concerned about the nature of decisions being made. Precedents emerging from the ADR process offer interpretations of the regulations which indicate that there is a significant dissonance between what the parties expect and what the adjudicators ultimately decree.[3] Although some discord between the two is inevitable, it should be limited only to unexpected factual issues or unanticipated interpretative rulings in certain cases. Multiple, compounding and unanticipated consequences, which are meted out by decisions but which are not obvious in the relevant statutory instruments, not understood by insurers, and not taken into account in product costing, push the system to the breaking point.

The current awards coming from the FSCO ADR process appear to lack a sense of cost-conscious pragmatism. The decisions rendered tend to have a tone of being anti-insurer at the risk of placing less importance on the rampant manipulation of claims.

[2] The number of cases in the system is, in itself, a concern. Notwithstanding the decline in accident rates and safer vehicles, the number of SABS cases seems to track incentives.
[3] This concern is magnified by repeated decisions where the ADR branch of FSCO makes policy decisions that are at odds with the position of other branches of FSCO.

Essentially, the Ontario automobile insurance system is a closed system. All of the costs and benefits are regulated by FSCO. An external observer would reasonably expect that costs would be based on a set of values consistently applied, whether in setting premiums, in regulating the users, or in ordering the payment of claims. There is little evidence of such consistency.

II. The Need for Recalibration Of the Balance in the FSCO ADR Process

Since the introduction of the SABS, a notion of entitlement has grown. Awards have moved away from a theory of compensation for out-of-pocket losses, towards a model that requires the payment of benefits in situations where there is no corresponding loss. Throughout the FSCO ADR process, there is less focus on the historical "common sense" approach relied on by property and casualty insurers, and increasing acceptance on the concept of entitlement as a matter of right. Claims that payors would have never thought reasonable or necessary in other injury compensation systems, such as the health care environment, are increasingly being demanded as a matter of routine in the automobile injury compensation environment. Those claims come at exorbitant costs.

This has resulted in the perception by users that the process has failed to focus on compensation for actual losses. Moreover, benefits awarded by FSCO arbitrators often bear no relationship to how health care needs are commonly addressed in the community, nor are claims examined in relation to any external norms.

Most FSCO arbitrators seem to be well aware of the fact that there are many abuses that occur in the injury compensation arena. These abuses may flow from representatives with conflicts of interest, fraud being advanced by, or on behalf of, claimants, health providers who put their own interests above the well-being of their patients, and claims personnel within the industry. The arbitrators have no tools to deal with system abusers, other than insurers. A strong and effective dispute resolution system is one that recognizes the importance of fighting fraud in the system.

Arbitrators deal harshly with insurers when findings of inappropriate conduct are made. It is a concern that the arbitration process might not be an appropriate arena for the exercise of this regulatory function. Given that many of the cases that reach the FSCO ADR process are often the most difficult cases to adjust, FSCO arbitrators seldom have the opportunity to see the insurance industry at its best. This fosters the development of a negative perception of insurers, which becomes embedded into the decision-making process. For example, some arbitrators perceive insurers to routinely enlist the assistance of medical assessors who are thought to provide distorted assessments which are against the interest of the injured claimant so as to advance the presumed goals of the insurer.

The stability, predictability and longevity of the automobile insurance system is dependent on a dispute resolution system which provides balance between protecting injured claimants, considering the interests of premium-paying consumers, and is sensitive to the wider impact on the insurance industry as a whole.

A. ADR is a Component of the Fight Against Fraud

Access to substantial economic benefits under the SABS scheme has become an attractive motivator for the perpetration of fraud and other egregious behaviour. Available compensation in excess of out-of-pocket losses is an invitation for abuse and fraud. Knowledgeable and informed arbitrators are in a unique position to identify, address and combat such behaviour. By adopting a principled approach of compensation for actual reasonable and necessary losses, as opposed to compensation based on a notion of entitlement, the motivation for fraudulent and other egregious behaviour would diminish sharply.

The dispute resolution system falls short when mediators make it a practice to pressure insurers to settle claims with little regard for the presence of potential fraudulent activities.

The prevalence of fraud and other egregious behaviour in the system is a strong indicator that the system is out of balance, and that there are insufficient impediments for those who demand payment for poorly justified claims. Adjudicators under the FSCO ADR process must be seen to apply value judgments informed by pragmatic and critical evaluation of real needs. Arbitrators have a critical role to play in dealing with these fundamental issues, and ultimately restoring stability to the system as a whole.

B. Lack of External Benchmarks for FSCO Arbitrators

We must put aside any notion that the design of the SABS and associated regulatory instruments creates an entitlement-based approach. We must turn to the real concern of imbalance in the system: the lack of any external benchmark for the value judgments made by FSCO arbitrators.

Arbitrators confine their activities to automobile SABS claims. It is a system rife with unique practices and demands. There is a "forest and trees" problem.

The first level of appeal from arbitration decisions is internal to the FSCO ADR process. Although some Director's Delegate decisions are successfully appealed to the Divisional Court, this is a rarity rather than the norm. Even if a particular arbitration decision may not be correct, courts are often reluctant to overturn arbitration decisions unless they are unreasonable.

Arbitrators are hampered by the lack of an external point of reference to inform their value judgments, as well as the reality that the FSCO ADR process is far too isolated from other compensation systems which adopt a different approach to the question of injury compensation.

C. Statutory Framework of the Automobile Insurance Regime

In the statutory framework which surrounds the Ontario automobile insurance regime, there are three sources of authority which ultimately determine the cost of the system:

(1) A body of regulations which are developed through the appropriate statutory authority, which also involves FSCO;

(2) A rule-making role for the interpretation of benefits under the SABS, which is authorized by sections 268.2 and 121(1) paragraph 10.2 of the *Insurance Act*; and

(3) Interpretation of the regulations at the end of the claims process by arbitrators and others, including courts.

The current FSCO ADR process often exhibits a disconnect between (1) and (3. More importantly, rule-making (2) is not used for any substantive purpose, which is quite surprising given the stability issues that plague the system.

D. Precedent Sources for Disputes under the SABS

Direction concerning the interpretation and application of the SABS are appropriately found in three main sources:

Regulations developed by statutory authorities, including FSCO;

Rules respecting the interpretation of the SABS, as authorized by sections 268.2 and 121(1) paragraph 10.2 of the Insurance Act; and

Court decisions based upon a thorough and reasoned analysis of competing policy interests.

The nature of the FSCO ADR process is to resolve disputes concerning the SABS in an expedient and inexpensive manner. As indicated above, this process has become strained with an overwhelming influx of claims, which further solidifies FSCO's mandate to deal with disputes in a timely and cost-effective manner.

Nonetheless, under the current process, FSCO arbitrators are being asked to produce decisions concerning disputes over the SABS on a regular basis. Given the complex legal issues that often emerge over such disputes, these decisions typically call for a detailed, thorough and probing analysis, as well as a balancing of various policy interests involved.

An ADR process which calls upon arbitrators, whose adjudicative functions are limited by cost, efficiency and an overwhelming number of claims, to render such dispositions does not achieve the goals of an efficient and cost-effective mechanism for resolving disputes. In fact, FSCO's mandate to create an ADR process which is expeditious and cost-effective is entirely inconsistent with the need to render decisions based on a thorough and probing consideration of complex legal issues and competing policy interests at stake for issues concerning the SABS.

Given this, coupled with the likelihood that many decisions regarding disputes over SABS-related issues will have an impact that is much more extensive than the individual claim at issue, SABS arbitrators should not be called upon as a precedent-making authority nor should they have the authority to make special awards. Rather, this responsibility would be better left to regulators, rule-makers and courts for a full consideration of the complex legal issues and policy considerations involved.

III. PROPOSAL FOR FSCO ADR Reform

Due to the burdens of increasing volume experienced under the current system, immediate improvements to the service level performance of dispute resolution activities are critical. Moreover, this is the moment to address the other issues in the ADR arena, in an attempt to bring some stability to the system. The following reforms, concurrently employed, are proposed:

1. Enlist private resources for ADR services. An effort at this is in place. This should be the default approach to addressing ADR;
2. Creation of a Medical Expert Panel;
3. Creation of rules for the interpretation and application of the SABS;
4. Creation of a consolidated appeal route;
5. Reform of various procedural deficiencies in the FSCO ADR process and matching of the process to the significance of the disputes; and
6. Track the types of cases that proceed to mediation to determine the reasons for the increase and how to ensure only legitimate cases are being heard.

IV. Recommendation 1: Enlist Private Resources for ADR Services

A. Mediation

The FSCO mediation process currently operates in an exhausted and overwhelmed forum. Recent efforts to reduce the strain on the system show some promise. But this has come very late, at great cost. The ADR management has not been nimble enough to address changing demands in a timely manner. Mediation and arbitration of the benefits provided in the SABS are mandated by statute to take place within two years after the insurer refuses to pay.[4] Mediation is expected to take place with 60 days of an application, a standard seldom met. Due to the increased demands in volume, FSCO has been unable to abide by these timelines.

In an effort to mitigate this, FSCO officially recognizes a mediation request when it is processed. However, this fails to address the more significant concern of a denial of access to justice for the users of the system, mostly claimants. It also has a negative impact on insurers who have an interest in resolving disputes within the system in an expeditious and efficient manner, and minimizing the risk that a number of unfunded or unrecognized liabilities are accumulating within the system.

The mediation process is fundamental to the operation of the SABS. It is intended as a control mechanism for ensuring that there has been basic compliance with the

[4] *Insurance Act*, R.S.O. 1990, c. I.8, ss. 280 & 281.1.

SABS by the claimant. This control mechanism is negated by the failure to provide timely access to mediation.

B. Regulator and Arbiter Roles Are Discordant

Under the present ADR system, FSCO plays two roles concurrently. It is the decision-maker concerning disputes over statutory accident benefits under the SABS. At the same time, it is the regulator of one of the parties to the dispute – the insurer. It is impossible for an adjudicator to be asked to be vigilant in ferreting out and punishing misbehaviour of one of the parties. This dual role is contrary to the basic principles of fairness, natural justice and due process which require independence and impartiality on behalf of adjudicators.

This concern is heightened when arbitrators are personally expected to perform a regulatory role in the course of an arbitration proceeding. They must notionally step out their role as impartial arbiter, and take on a prosecutorial role to deal with a claimed "special award". Arbitrators frequently go further than this. They have, on their own initiative, decided to grant a special award in cases where none has been sought. Aside from the procedural unfairness to the parties, this takes the arbitrator unacceptably out of an impartial status.

Mediators are in a difficult position to maintain the appearance of impartiality. The FSCO mediator assigned to a dispute shares the same office as FSCO in its capacity as the regulator of insurers. FSCO's role as regulator includes the ability, among other things, to make orders against insurers for unfair and deceptive acts and practices, regulate premiums, and draft the language of the regulations that ultimately binds insurers. Given the close connection between a regulator with a significant amount of control over the operations of the insurer and the mediator that is obliged to be independent and impartial, it is clear that an appearance of bias is a real risk.

The conflict between the regulatory and adjudicative functions has been highlighted in other sectors. In his report studying the process used to audit the fee claims submitted by physicians to OHIP, the Honourable Justice Peter Cory addressed whether the Medical Review Committee had jurisdiction to review and audit physician's fee claims while at the same time acting as the body that regulates physicians.[5] Justice Cory concluded that the audit process must have the complete confidence of physicians, it must be transparent, the process must be fair, unbiased, qualified and independent, and the system must be easily understood, functional and practical. In sum, he concluded that independence between the arbiter and the regulator is critical.

[5] Study, Conclusions and Recommendations pertaining to Medical Audit Practice in Ontario, The Honourable Peter C. Cory (Queen's Printer: April 2005).

The stability of the FSCO ADR system is dependent upon the confidence of its users. User confidence is derived from a transparent, functional and practical system adjudicated by unbiased, fair-minded, qualified and independent arbitrators. A system which separates the naturally incongruent roles of regulator and arbiter is required in order for the system to function effectively and restore stability and certainty to the regime.

Ontario's insurance laws have been recently amended to embrace "Administrative Monetary Penalties" as a regulatory tool to address non-compliant behaviour. There is no practical need to put arbitrators is the position of operating a parallel, uninformed program of regulatory supervision.

C. Creating Mediator and Arbitrator Rosters

External to FSCO there is an abundance of ADR resources. Mediation is extremely common, and mediators are readily found with a variety of expertise. Private arbitration has also assumed a growing importance in the dispute resolution arena. Ontario legislation already sets out the substantive and procedural rules that apply to private arbitrations. A practical solution for the rehabilitation of the SABS mediation and arbitration process has been to create rosters for both mediators and arbitrators, enlisting these resources. In our view, this process should be taken to its logical outcome. The services should all be outsourced. FSCO's role should be a supervisory role, consistent with its position as overseer of the entire system.

Ontario has elsewhere adopted private mediation models, utilizing private resources in a regulated regime. The Ontario Mandatory Mediation Program for actions brought in the Superior Court of Justice uses a private delivery model for mediation services. Adopting a similar approach in the SABS ADR realm should address the existing concerns with respect to natural justice and due process associated with FSCO's dual role as both regulator and arbiter.

The Ontario *Rules of Civil Procedure* uses this approach to facilitate mediation of litigation matters. The rules prescribed by the Ministry of the Attorney General provide that a mandatory mediation session must take place following the delivery of a Statement of Defence in actions brought in the Superior Court of Justice.[6] The process is implemented by establishing a roster of mediators.

In an effort to streamline this approach with the SABS ADR system, the same roster could be used as a starting point to identify appropriate persons to conduct SABS mediations and arbitrations under a private delivery model.

The statutory authority to create such rosters already exists. Section 9 of the *Insurance Act* addresses the appointment of FSCO mediators and arbitrators, which provides as follows:

[6] *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194, r. 24.1.

Mediators

9. The Superintendent may appoint employees of the Commission or other persons to act as mediators. (emphasis added)[7]

Arbitrators

8. (1) The Superintendent shall establish and maintain a roster of candidates chosen by the Superintendent from the persons recommended to conduct arbitrations under this Act by the committee appointed under section 7.[8] (emphasis added)

The roster would list those individuals who are prepared and duly qualified to mediate and/or arbitrate. This initial roster of mediators and roster of arbitrators could then be expanded so as to add eligible lawyers and individuals with appropriate experience as mediators, and eligible lawyers with experience or training in adjudicative processes as arbitrators.

Procedural rules would also be required to prescribe the process for mediator and arbitrator selection by the parties. If the parties agree on a mediator or arbitrator to use from the particular roster, then that individual would proceed to preside over the dispute. If the parties are unable to agree on a mediator and/or arbitrator, a process similar to that of the Superior Court of Justice would be appropriate. Under that process, a random mediator is selected from the roster by the Local Mediation Coordinator. In the case of FSCO, for situations where the parties are unable to mutually select a mediator or arbitrator, the mediator or arbitrator could be randomly selected.

Mediation, pre-hearing and arbitration scheduling would require some administrative support. In September 2011, DRSB introduced an e-calendar process for booking mediations and arbitrations, which would appear to reduce a dependency on staff employed by FSCO for such administrative purposes.

D. Fee Structure for Mediators and Arbitrators

The Ontario Mandatory Mediation Program has a set fee schedule.[9] The scheduled fees cover one hour of preparation time and up to three hours of the mediation session. The mediator's fee cannot exceed $600 for actions involving up to two parties.

[7] *Insurance Act*, R.S.O. 1990, c. I.8, s. 9.
[8] *Ibid.*, ss. 7 & 8.
[9] *Mediators' Fees (Rule 24.1, Rules of Civil Procedure*), O. Reg. 451/98, s. 4(1), made under the *Administration of Justice Act*, R.S.O. 1990, A.6.

An evaluation of the first 23 months of the Ontario Mandatory Mediation Program concluded that the program resulted in reduced costs to litigants, and had a positive impact on 85% of cases.[10]

The FSCO mediation process would benefit from a fixed fee structure that affords remuneration according to the duration of the mediation session, with a fee payable by insurers to private mediators as opposed to FSCO.

With respect to arbitration, the proposed structure of compensation would be for insurers to fund the cost 100% on the basis of a fixed base fee for the arbitration generally, plus a modest per diem fee for each day required for the arbitration hearing. This would promote an efficient and cost-effective hearing process, thereby rendering the current $3,000 arbitration fee redundant. The claimant would simply remain responsible for the applicable application fee. Of course the arbitrator would retain the authority to make some other order with respect to the fees where the circumstances require it.

Mediators' and arbitrators' fees being paid wholly by the participating insurer means that only insurers who are engaged in a particular dispute are required to cover the cost. Moreover, relying on private mediators and arbitrators to resolve disputes under the SABS will create competition, which may have the effect of better facilitating settlements at mediation, and rendering of arbitration decisions promptly.

The dispute resolution environment will be enriched by the diversity of experience and skills of the mediators and arbitrators that will inform the SABS resolution process.

[10] *Evaluation of Ontario Mandatory Mediation Program: The First 23 Months* submitted to Civil Rules Committee, Robert G. Haan et al. (Queen's Printer, 2001).

E. Advantages of Privatization of Mediation and Arbitration

In light of the significant backlog being experienced at FSCO, particularly for those cases in the mediation stream, additional resources are critically needed. Supplementing the existing system with private providers to conduct mediation sessions and arbitration hearings will facilitate the required resources.

Privatization of FSCO ADR will also have the important effect of separating FSCO's role as regulator from its role as mediator/arbiter, and introduce impartial mediators and arbitrators who are insulated from FSCO's function, system and values as a regulator.

V. Recommendation 2: Creation of a Medical Expert Panel

Currently arbitrators do not have access to a neutral benchmark for the generally-expected medical course for claims under the SABS. We propose engagement of an independent and unbiased medical expert panel, mandated to provide insight on the evidence-based state of medical knowledge. The panel would inform the process as to the nature of a particular claim with reference to generally accepted medical norms.

A medical expert panel would assist to expose abuses within the system, and provide benchmarks and education for the benefit of the arbitrators and other users of the system.

A. Statutory Authority for Creating a Medical Expert Panel

The statutory authority for creating such a Panel already exists. The *Insurance Act* allows the Minister or Superintendent to appoint a Minister's committee to perform whatever functions are assigned to it.[11] Using this authority, it would be possible to create a committee of disability and rehabilitation experts to perform a screening function with respect to cases coming through arbitration.

B. Role of the Medical Expert Panel

The role of the medical panel would be to conduct a paper review of the particular claim for healthcare and disability costs, and to provide a report simply to set out the parameters of the expected norms typically associated with the claim, founded on medically-based evidence. The report would not prejudge the outcome, but would set the context for evaluating the claim on its merits. In particular, the report would establish the following:

Whether the type of impairment diagnosed is a common diagnosis,

[11] *Insurance Act R.S.O. 1990, c. I.8, s. 7.*

Whether the disability alleged in relation to the impairment is the kind of disability, both in terms of character and duration, normally encountered for this diagnosis of injury,

What the normal modalities of treatment are for such injuries, as well as the frequency and cost of the treatment based upon similar claims grounded in evidence based medicine,

Whether the diagnosis is one normally made after an event such as the accident in question, and

Additional comments on the treatment offered and claimed.

The report would provide an anchor or benchmark regarding the generally expected medical course for a kind of case. The arbitrator would then be in a better position to understand the assertions made by the parties, and determine whether evidence justifying the claim is required. Arbitrators would more easily recognize allegations that are outside of medical norms, and would accordingly be in a position to require cogent and convincing evidence to sustain the allegations.

The panel would also play an important role in assist with the elimination of abuses. For instance, it could be part of the panel's role to report issues of competence and dishonesty to the appropriate medical college. The panel could also make referral to investigators who might be charged with looking at any portrayed improprieties, promoting compliance with the SABS. Reporting such issues would result in a repository of intelligence identifying the players in the system that appear to be repeatedly engaging in questionable practices.

As indicated above, the involvement of the panel would be strictly limited to providing background for the arbitrator – not to provide a judgment or assessment with respect to any of the actual entitlement issues. Furthermore, the panel would not be tasked with reviewing lengthy volumes of medical documentation for the purpose of preparing the report. Rather, brief summaries concerning the claimant's condition and course of treatment would suffice for this purpose, which would reduce the time and expense associated with this role.

C. Qualifications of the Medical Expert Panel

As part of their role, the panel would be obligated to provide comments on the particular claim based on generally-accepted medical and scientific principles.

In terms of who would qualify to be on the panel, panel members would ideally be nominated by their respective regulatory college, and be members or designates of their respective quality assurance committees[12].

D. Advantages of the Medical Expert Panel

There are a number of advantages to making use of the existing statutory authority to create a medical expert panel. Those advantages include the following:

Neutral expertise is brought to each case, at a relatively low cost,

A benchmark is created for the evaluation of entitlement in each case,

The system users will become more educated about mainstream medical science and generally-accepted norms for the course of claims, and

Abusers of the system will be identified and appropriately reported by the panel members.

VI. Recommendation 3: Employ Existing Provisions to Promulgate Rules for the Interpretation of the SABS

The interpretation of the SABS by arbitrators (and courts) is often inconsistent and unpredictable. At present, there are hundreds of precedent arbitration decisions on various principles of interpretation, which are far from consistent. Moreover, there have been numerous inconsistencies between FSCO arbitration decisions and court decisions on similar issues. Often outcomes achieved tend to depend more on the dispute resolution mechanism, instead of substantive rights or merits.

Ancillary to inconsistent interpretations is the tendency of arbitrators to expand or contract insurance coverage.[13] Given that this is a business model which is statutorily mandated, and the impact potentially increases the cost to premium-paying consumers, it is questionable whether this is a proper function of the arbitrator. Arbitrators are not equipped with the appropriate resources to make those types of decisions, and may not appreciate the wide-reaching impact that their decisions may have on claimants, consumers and the industry.

[12] All health professions are regulated by colleges and the colleges are required to have a Quality Assurance Committee.
[13] *Mariona and Canadian General Insurance Company*, FSCO A96-000717 (September 25, 1998, Arbitrator Alves).

In *Aviva Canada Inc. v. Pastore*,[14] the Divisional Court observed that the Director's Delegate in that case rendered a decision related to benefits under the SABS which ignored evidence which provided the context or "surroundings that colour the words" of the legislative provision at issue, from which the legislative purpose is to be derived. The need to take into account a broader context is not optional.

One potential solution to this problem would be to maintain regulatory/supervisory control over precedents concerning interpretation of the SABS by promulgating rules address SABS disputes and issues. These rules would serve to provide a pronouncement of what the appropriate interpretation should be, which would afford a significant degree of clarity, consistency and order to the application and interpretation of the SABS.

FSCO is essential to the efficient and consistent operation of the automobile injury compensation system. It has also played a key role in the development of the benefits schedule; it issues informative guidelines and bulletins, and governs both pricing and service delivery. FSCO, through the Rule making mechanism, is in a unique position to rectify unexpected court and/or arbitral decisions that tend to upset the predictability and efficiency of the system. The creation of interpretative rules would serve to correct this disharmony, and restore clarity.

Rule making need not be only reactionary. Rather Rule making would be best employed to address emerging issues. Time is of the essence for all concerned.

A. Legislative Authority

The *Insurance Act* grants authority to create rules of interpretation in section 268.2. According to paragraph 10.2 of section 121(1) in the *Insurance Act*, the Lieutenant Governor in Council is permitted to make regulations prescribing rules for interpreting, the terms, conditions, provisions, exclusions and limitations related to benefits under the SABS.[15] As such, the creation of rules could be accomplished without resorting to statutory or regulatory amendment. The relevant statutory provisions read as follows:

[14] 2011 ONSC 2164 (Div. Ct.).
[15] *Insurance Act*, R.S.O. 1990, c. I.8, s. 121(1), para. 9.

Rules of interpretation, *Statutory Accident Benefits Schedule*

268.2 The *Statutory Accident Benefits Schedule* shall be interpreted in accordance with the rules made under paragraph 10.2 of subsection 121 (1). 1993, c. 10, s. 27; 1996, c. 21, s. 31.[16]

Regulations

121. (1) The Lieutenant Governor in Council may make regulations,

9. establishing benefits for the purposes of Part VI that must be provided under contracts evidenced by motor vehicle liability policies and establishing terms, conditions, provisions, exclusions and limits related to such benefits;

10.2 prescribing rules for interpreting the regulations made under paragraphs 9 and 10 or any provision of those regulations;

This legislation speaks loudly about the intended role of government in SABS interpretation. This function needs to be reclaimed from the ADR process.

B. Publishing a Consolidation of Interpretative Rules

In order to facilitate widespread dissemination and knowledge, it would be appropriate for the Superintendent to publish a consolidation of the interpretive principles concerning the SABS. The publication would be revised on an as-needed basis, perhaps as issues emanating from arbitration and court decisions and handling problems are reported by users of the system. The consolidation should be widely distributed at least once annually.

A widely published and accessible consolidation of these interpretive rules would simplify entitlement determination and reduce the cost to insurers, customers and dispute resolution personnel. System users would have ready access to the core rules without the challenge of locating, analyzing and rationalizing a variety of case decisions.

C. Examples of Interpretive Rules Required

Communication and Disclosure Obligations

Communication and disclosure are critical elements of the SABS. The regulations do not explicitly instruct insurers regarding what their obligations are when it comes to communication and disclosure requirements. FSCO decisions contribute to the uncertainty of principles interpreting the SABS by defining the insurer's duty on an inconsistent basis. This uncertainty may have a tendency to exposes insurers to the consequences of improper communication and disclosure.

[16] *Insurance Act,* RSO 1990, c I.8.

As a result, there is a need for FSCO, as a prudent regulator, to provide an unambiguous pronouncement of precisely what the insurer's obligations are when it comes to their communication and disclosure requirements. Standard forms and a body of rules that provide what is expected of insurers would assist in this regard. Such standard forms and rules would allow insurers to know whether they are compliant with the SABS well before the dispute resolution stage. Whether an insurer is compliant with its obligations under the SABS should not be determined on an ad hoc, after-the-fact basis.

Insurer's Examinations, Designated Assessment Centre Reports and Time Limits

A further interpretive issue concerning the SABS is that there is no recourse for insurers to dispute an insurer's examination or a Designated Assessment Centre's ("DAC") assessment report if they disagree with the conclusion in such report. Once a report has been received, an insurer is prevented from obtaining a second opinion. Such assessments are binding on insurers.[17] Conversely, an insured is not bound by any medical reports that he or she does not rely upon.

The SABS impose unreasonable time limits within which to obtain and pass information regarding insurers' examinations.[18] A claimant's benefits will be suspended if he or she fails to provide reasonably available information and documents relevant to his or her medical condition within five days after receipt the insurer's notice of examination.[19] Insurers are under very tight deadlines to respond to requests for funding and completion of insurer's examinations.

Special Awards

In recent years, special awards have increasingly been ordered at an unprecedented rate, both in terms of volume and quantum. In a July 2010 FSCO arbitration decision, the arbitrator provided heavy criticism of the insurer for relying on what was described as a "cowboy assessment" that suited the insurer's needs or the assessor's own preferences.[20] A special award was ordered at the high end of the spectrum (40%).

As noted earlier, arbitrators have ordered special awards even in circumstances where they have not been advanced by the applicant.[21] Justification for the award has been cited as the wording of the SABS, such that an arbitrator "shall" order a special award if benefits were unreasonably withheld by the insurer.[22]

FSCO arbitrators have also allowed a special award claims to proceed to arbitration where there are no other benefits in dispute. The justification for this approach has

[17] *Murray and Aviva Canada Inc.*, FSCO A07-000015, September 7, 2007 (Arbitrator Wilson).
[18] *Insurance Act*, R.S.O. 1990, c. I.8, s. 121(1), para. 42.
[19] *Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996*, O. Reg. 403/96, s. 42(10).
[20] *Sinnapu and Economical Mutual Insurance Company*, FSCO A09-000900, July 30, 2010 (Arbitrator Wilson).
[21] *Stargratt and Zurich Insurance Company*, FSCO A99-000521 (October 4, 2001 (Arbitrator Wilson).
[22] *Insurance Act*. R.S.O. 1990, c. I.8, s. 282(10).

been cited as a method of "filling the gap" left by the absence of punitive and aggravated damages in FSCO arbitrations.[23] Conversely, special awards sought in the Courts tend to be denied. Courts have held that the statutory award of interest at the rate of 2%, compounded monthly, is sufficient "punishment, deterrence and denunciation," and that a special award would serve no useful purpose.[24]

There are ample inconsistencies between FSCO arbitration and court decisions. These inconsistencies create uncertainty for claimants and insurers. The Divisional Court's commentary in the *Pastore* decision demonstrates that special awards ordered by arbitrators are not justified in a system that lacks consistency and appreciation for the larger context in which the SABS operates.[25]

As indicated above, Justice Cory's analysis of the OHIP process for auditing physician's bills correctly identified that significant due process concerns exist in circumstances where the adjudicator of a dispute is the same body as the enforcer of the regulations.[26] This poses significant problems for the obligation to engage in the impartial and independent adjudication of disputes, especially with respect to special award claims in particular.

The pronouncement of interpretive rules would achieve consistency among arbitral and court decisions relating to the SABS, which would in turn reduce the cost, delay and confusion often experienced by users of the current system.

Catastrophic Impairment

The need for a set of interpretive rules is also evident from the current state of the law regarding the determination of which claimants meet the definition of catastrophic impairment under the SABS.

Court decisions have changed the landscape on CAT evaluation. In particular, courts have required that mental and behavioural impairments must be taken into account when determining a "whole person impairment" under the AMA Guides as referenced in the SABS. But neither the regulations nor the AMA Guides offer any methodology for putting the court-mandated approach into practice. As a result different methodologies are tendered in each case, with arbitrators being asked to apply external resources to recast the regulation in an unsanctioned fashion. They are again being asked to make policy, without the resources or process to evaluate the merits of the various proposals. This is clearly an area that cries out for direction. If the courts will not provide the needed clarity then a rule of interpretation could give that direction.

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[23] *Shaikh and Aviva Canada Inc.*, FSCO A09-000013, December 30, 2009 (Arbitrator Wilson).
[24] *Liss v. Kingsway General Insurance Company*, 2005 CarswellOnt 7905 (Sup. Ct. J.).
[25] *Aviva Canada Inc. v. Pastore*, 2011 ONSC 2164 (Div. Ct.).
[26] Study, Conclusions and Recommendations pertaining to Medical Audit Practice in Ontario. The Honourable Peter C. Cory (Queen's Printer: April 2005).

The creation of such a rule pronouncing the correct interpretation of the regulatory provision in the SABS which speaks to determining catastrophic impairment would clarify the confusion that has resulted in the wake of these decisions for all of the players involved.

Minor Injury Definition

A very large number of cases are in dispute presently over the question of whether or not a particular impairment is a minor injury or not. Many of these cases raise identical issues. It may be many years before the courts and arbitrators land on a consistent approach to some of these recurring issues. This is unsatisfactory.

The effect of an unexpected determination of what constitutes a "minor injury" could be very destabilizing. There might be very substantial unfunded liabilities as a result.

It is obvious that some of these issues call for a policy making decision, and ought not be left to emerge from some dispute resolution process of unknown dimension.

Non Earner Benefits

Unexpectedly case law has opened up a second stream of benefits for disabled claimants. As an alternative to income replacement benefits, the SABS provides a disability-based benefit for "non-earners." The challenges of administering such a benefit, and the implicit moral hazard of the concept, has motivated government to reduce this benefit drastically since it was first introduced. But it remains in place for disability greater than six months duration.

Users have considered the access to IRB and NEB to be mutually exclusive. It has been commonly accepted that an injured claimant would not be eligible for both categories of benefit.

Recent case law suggests that a claimant who returns to employment and ceases entitlement to IRB may then be entitled to NEB.

This position, the disclosure obligations associated with this interpretation, and the effect of IRB termination on future entitlement are topics that could be usefully addressed by interpretive rules.

Optional Benefits

Case law has canvassed the obligations of insurers with respect to offers of optional benefits.

Clearly such communications are made in the context of sales transactions, not claims transactions. Courts have embraced an onerous standard for insurers that

may not be practical to apply in the very high volume of transactions that are involved.

Nor is it clear that any perceived deficiency in the optional benefit transactions should result in access to optional benefits that were neither purchased nor paid for.

Recasting of significant SABS from mandatory to optional is a major tenet of governments cost reduction strategies. There is a profound regulatory interest in having the offer process set out in a clear and comprehensive manner.

Additional Considerations

In addition to the above, there are several other instances of precedent-setting FSCO decisions which appear to change the scope and cost of the SABS. For instance, collateral benefits, self-employed cases, regular use and dependency, and many other issues requiring an interpretation of the SABS could be clarified through the creation of interpretive rules.

Frequent regulatory attention to the precedents created by courts and arbitrators is a necessary component of a stable auto insurance system. Interpretive rules would allow the SABS to be brought back into line with its original design. The ultimate interpretive role would appropriately be returned to the legislative realm, in which there is accountability to all users of the system. The interpretive rules would essentially be the primary guidance for determination of SABS disputes, and serve to minimize the inconsistency and confusion that is frequently encountered under the current system.

VII. Recommendation 4: A Consolidated Appeal Route

The multiplicity of venues for the resolution of SABS disputes presents a problem as well. At present, the appeal of a decision on a SABS dispute might go to the Director's Delegate at FSCO on appeal from an arbitration decision, or it might go to an appellate court on appeal from a court decision. Having the same issues in dispute routed to two different, non-overlapping jurisdictions creates confusion. Instead, there should be one appeal route for all SABS disputes.

A streamlined approach for the route of appeal from a FSCO arbitration decision would be useful to address this problem. For example, the Ontario *Arbitrations Act* directs that all appeals be routed into the court system. By following this approach, all appeals of decisions relating to SABS disputes, whether from FSCO arbitrators or courts, would be heard by a judge of the Superior Court. As a result, users of the FSCO ADR process would benefit by having to look to only one source for consistent and identifiable appellate jurisprudence on SABS-related issues.

VIII. Recommendation 5: Fix Procedural issues in the Current ADR Model

In addition to the various substantive problems identified with the FSCO ADR process, there is a wide and varied range of procedural problems experienced by the users of the system. As such, reform as it relates to the various procedural flaws in the system is necessary in order for the system to function with minimal complexity and consistency. Below is a review of certain procedural irritants which have been identified; however, this is only a selection of those, and can be expanded upon by frequent users of the system.

Amendment of the rules of practice and procedure contained in the Dispute Resolution Practice Code ("DRPC") would be the most efficient route to reform of the various procedural deficiencies. Authority for such amendment is found in sections 6 and 21 of the *Insurance Act*[27] and section 25.1 of the *Statutory Powers Procedure Act*.[28]

Implementation of the following amendments to the FSCO ADR procedure ought to be carried out in a coordinated, thoughtful and calculated manner so as to ensure cohesiveness and acceptance of the reforms among the end users of the process.

[27] R.S.O. 1990, c. I.8, ss. 6 & 21.
[28] R.S.O. 1990, c. S.22, s. 25.1.

A. FSCO Mediations

Courts have recognized that the quality of FSCO mediations is generally inconsistent.[29] The predominance of FSCO mediations being held by telephone has a significant impact on quality and consistency. Telephone mediations eliminate the ability of the insurer to see, assess and interact with the claimant. To the contrary, in-person mediations tend to be resolved by settlement more frequently than those conducted via telephone.

When mediations are conducted by telephone, there is a certain degree of ambiguity and confusion as to whether the authority to settle a file at mediation exists. There are little to no consequences for a party's failure to attend at a mediation session. Failure to attend the mediation raises doubts to whether a settlement can be effected, and also raises suspicions of potential fraudulent or other egregious activity. Attendance at mediation accomplishes the objectives of, among other things, understanding each party's case, interests and position as to specified benefits, assessing the claimant, facilitating settlement, and combating fraud and/or other egregious conduct.

B. Preliminary Ruling on Jurisdictional Issues

Too often it seems that FSCO mediation is improperly used as a basin to catch disputes that should not be proceeding to the dispute resolution stage. The SABS flatly precludes access to mediation in several circumstances. [30] But nothing prevents a claimant from actually entering the mediation process. Under the FSCO ADR regime, the mediator is not in a position to deal with jurisdictional arguments concerning whether a claimant is entitled to proceed to dispute resolution. Counsel who raise jurisdictional arguments at this stage force the mediator to fail the mediation, and allow the claimant to proceed to arbitration.

The creation of a procedural rule would be useful for when a jurisdictional argument is raised by the insurer. One of these rules would be to require the

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[29] *Hastings v. Royal & SunAlliance Insurance Co. of Canada*, 2009 CarswellOnt 9580 (Sup. Ct. J.) at para. 6.

[30] **55.** An insured person shall not commence a mediation proceeding under section 280 of the Act if any of the following circumstances exist:

1. The insured person has not notified the insurer of the circumstances giving rise to a claim for a benefit or has not submitted an application for the benefit within the times prescribed by this Regulation.
2. The insurer has provided the insured person with notice in accordance with this Regulation that it requires an examination under section 44, but the insured person has not complied with that section.
3. The issue in dispute relates to the insurer's denial of liability to pay an amount under an invoice on the grounds that,
    i. the insurer requested information from a provider under subsection 46.2 (1), and
    ii. the insurer is unable, acting reasonably, to determine its liability for the amount payable under the invoice because the provider has not complied with the request in whole or in part. O. Reg. 194/11, s. 3.

mediator to refer the factual or legal issue to an arbitrator for a preliminary issue hearing. The arbitrator would then adjudicate the jurisdictional issue only. If jurisdiction is affirmed and the claimant is entitled to mediation, the matter would then be referred back to the mediator for a mediation session.

C. FSCO Pre-Hearings

FSCO telephone pre-hearings tend to be cumbersome, ineffective and isolate the parties. Face to face pre-hearing discussions, on the other hand, are much more meaningful, and enhance the dispute resolution process by engaging the parties. Geographical problems present certain challenges, but resorting to a telephone pre-hearing risks sacrificing significant value that can be found in the process.

The failure of a claimant's or insurer's representative to attend a pre-hearing is a particularly troubling concern. Non-attendance at FSCO pre-hearings ought to have certain consequences, given that it significantly prejudices the other party from being able to meet its case. While some exceptions may be acceptable, such as medical reasons preventing attendance, but a presumption of fulsome participation must be alive within the system.

D. An Oral Discovery Process at the Arbitration Stage

Under the current FSCO ADR system, no procedure for formal discovery at arbitration exists. Section 33 of the SABS allows an insurer to exercise a limited right to require that the claimant submit to an examination under oath. Several arbitral decisions indicate that an insurer is precluded from requiring claimant to undergo an examination under oath once the arbitration process has commenced.[31] This deprives the insurer of the opportunity to see and assess the claimant in person.

Whereas pre-hearing testimony under oath is a common tenet of due process which operated under civil litigation regimes, it is absent from the FSCO ADR process. The result is that the parties are each deprived of the opportunity to know the case it has to meet at arbitration until the actual hearing commences. A prescribed process which requires the parties to clearly articulate their positions and commit to an evidentiary record would bring the parties closer to a resolution by way of a settlement, and would also shorten the time required for arbitration hearings.

The Ontario Court of Appeal has held that the purpose of examinations for discovery is "to enable the parties to know the case they will have to meet at trial, prevent surprise and to obtain admissions or other information which will reduce the

[31] In *Salah and State Farm Mutual Automobile Insurance Company*, FSCO A04-000210 (October 28, 2005, Arbitrator Miller), the Arbitrator refused to grant the insurer's request to adjourn the arbitration hearing so as to conduct a section 33 examination under oath. *Balanki and Zurich Insurance Company*, FSCO A04-002286 (February 15, 2005, Arbitrator Muir), the arbitrator stated that he had no authority to stay the arbitration to allow the insurer to conduct an examination under oath under s. 33.

expense of preparing for and participating in the action."[32] Denying the insurer an opportunity to obtain sworn oral evidence from the claimant prior to the arbitration hearing prevents the insurer from knowing the claimant's case, position and interests, ability to obtain admissions that may tend to shorten the proceedings, and also from combating fraud and other egregious behaviour. The claimant is similarly handicapped by the lack of discovery process.

A limited form of oral discovery, which currently exists under the Simplified Procedure of the Superior Court of Justice, would benefit the arbitration process by identifying key facts and admissions, and have a tendency to promote and encourage settlement.

Truly some cases in ADR are too modest to warrant engagement of costly and time consuming legal processes. There is much to be said for recognition of different levels of procedure, commensurate with the nature of the case under consideration.

E. Exchange of Documentary Evidence

After a request is made by a party to the FSCO ADR process, the arbitrator determines which documents are to be exchanged.[33] Unlike the civil litigation process in the Superior Court of Justice, no obligation exists to compel a claimant to produce medical records and reports or for either party to provide a sworn document disclosing all documents in the party's possession, whether they object to producing them or not.

The DRPC places a positive obligation on the insurer to provide copies of all documentation received to the claimant and an ongoing mutual obligation of disclosure. The DRPC requires an interlocutory procedure for parties to bring a motion to compel the production of documents and the completion of medical authorizations.

However, under the current process, the parties are only required to exchange documents, reports and assessments that they intend to introduce at arbitration 30 days before the hearing commences.[34] The hearing arbitrator then determines the relevance, materiality and admissibility of evidence submitted at the hearing.[35] Rules which are stricter in terms of timelines for the exchange of documents would promote transparency and settlement.

F. Medical Examinations

[32] *Gemini Group Automated Distribution Systems Inc. v. PWA Corp.*, 1993 CarswellOnt 465 (C.A.) at para. 22.
[33] *Dispute Resolution Practice Code*, Financial Services Commission of Ontario, r. 32.
[34] *Dispute Resolution Practice Code*, Financial Services Commission of Ontario, r. 39.1.
[35] *Ibid.*, r. 39.3.

Under section 42 of the SABS, the insurer has the right to require the insured to be examined so as to determine whether that person is or continues to be entitled to benefits.[36] However, FSCO arbitrators have imposed significant restrictions on when and how the insurer may exercise this right. The restrictions appear to result from a perceived concern that the examination is exercised to bolster the insurer's evidence at the time of the arbitration hearing.[37]

In an effort to deal with this, a procedural reform could be initiated so as to require the medical examination to take place after the mediation, but before the pre-hearing, so that the insurer is in a position to assess the claimant's current status. This operates similar to the Superior Court of Justice medical examination procedure provided for in Rule 33 of the *Rules of Civil Procedure*.

G. Surveillance Evidence

Another concern with the current process is that the language of the DRPC creates ambiguity as to whether surveillance or investigative evidence must be produced, and whether it must only be produced if a party intends to rely on a portion of that evidence at arbitration.[38] Some FSCO arbitrators have interpreted Rule 40.1 of the DRPC to require that all of the insurer's surveillance and investigation evidence be produced once its existence becomes known, even if the insurer does not intend to rely on a portion of it at the hearing.[39]

It is necessary to strike a balance between the desire to avoid surprise at arbitration and the use of surveillance as tool to identify fraud and dishonesty. Requiring the production of all surveillance evidence may have the effect of actually facilitating fraud in certain circumstances by educating a dishonest witness about which factual assertions will expose a lack of veracity by the claimant. In a system which is challenged to identify and fight fraud and other egregious behaviour, early disclosure of surveillance and investigative evidence should yield to combating fraud and searching for truth in instances where fraud is suspected.

H. Witnesses

The current DRPC places no limit on the number of witnesses that may be called at an arbitration hearing. The current practice is to exchange witness lists, which can often be exorbitant and impossible for the other side to decipher and accurately estimate which witnesses will actually be summoned to the hearing.

[36] *Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996*, O. Reg. 403/96, s.42.
[37] *Karn and Western Insurance Company*, FSCO A05-000136 (April 10, 2006, Arbitrator Miller).
[38] *Dispute Resolution Practice Code*, Financial Services Commission of Ontario, r. 40.1.
[39] *Suhanic-Knox and Economical Mutual Insurance Company*, FSCO A08-000767 (January 6, 2009, Arbitrator Wilson).

The parties are only required to disclose which witnesses they intend to call 30 days prior to arbitration.[40] Efficiency and transparency during the arbitration process warrants the DRPC to prescribe a more suitable timeline and limits on the number of witnesses which may be relied on to provide evidence at a hearing.

I. Length of Arbitration Hearings

FSCO's stated mandate is to provide an ADR process that is quicker and more efficient than that which would be expected under the court system. However, this is not always the case. In an effort to ensure that hearings are not proceeding in an efficient and cost-effective manner, one change which is warranted is an amendment to the DRPC so as to restrict the number of days an arbitration hearing can proceed. Amendments limiting the number of witnesses allowed to testify at a hearing and rules which place importance on pre-hearing testimony and fulsome documentary disclosure early on in the process are also warranted. The combined effect would have the positive result of having an efficient process that is actively resistant to fraud and other egregious behaviour, and routinely seeks to discover the truth among the facts and issues in dispute between the parties.

J. Dismissal Orders

Based on reports from users of both sides of the system, it currently takes many months for FSCO to distribute signed consent dismissal orders to the parties. This appears to be due to administrative backlog within the system, which FSCO does not currently have the resources to address. An amendment to the DRPC to create an administrative position akin to a Court Registrar is warranted so as quickly execute consent dismissal orders and allow the parties to move on from the dispute much sooner.

[40] *Dispute Resolution Practice Code*, Financial Services Commission of Ontario, r. 41.1.

K. Tiers of Procedure

Just as our court system strives to match resources to the cases before it by differentiation (Small Claims, Simpified Rules, Other Cases), SABS ADR might benefit by enhanced legal processes where appropriate. As a more comprehensive approach to ADR reform, there is value in considering a system that is more nuanced in its application to disputes.

Obviously the cases that involve the most money are the cases that most clearly justify the possibility of more elaborate process and additional costs.

We would suggest that cases be triaged by monetary significance along the following lines:

1. Cases that have one of:
    a. Disability based benefit more than 90 days
    b. Treatment or service costs paid and requested that in the aggregate exceed $50,000
    c. Declaration of CAT status.
    d. Attendant Care claimed greater than $500 per month or $25,000 in the aggregate.
2. Cases that are for:
    a. Treatment or service cost paid and requested that in the aggregate are less than $10,000
    b. Disability based benefit of 30 days or less
    c. Right to mediation where the person is alleged to have failed to comply with a precondition to mediation.
3. All other cases.

Using this categorization, we would suggest that the appropriate process would be

1. A fulsome process with production of documents, discovery, requests to admit, formal offers and cost consequences. Adjudicators should be the most experienced. Mediation would take place after discovery.

2. A simplified process that goes directly to binding dispute resolution without intervening steps and without determination of any issue that impacts entitlement if the case moves into a more serious tier. Hearing time would be short.

3. A process similar to today's process with mediation and binding dispute resolution.

IX. Recommendation 6: Track the types of cases that proceed to mediation to determine the reasons for the increase and how to ensure only legitimate cases are being heard.

It is important that that dramatic increase in mediation applications over the last 5 years be tracked and analyzed to determine the actual causes for the increase.

Alternative Dispute Resolution (ADR) is meant to resolve disputes in a fair and expeditious way. The Insurance Act requires that mediation be completed within 60 days of the filing of an application unless both parties agree to an extension. It is troubling that under the current system legitimate claimants have to wait up to two years for a hearing.

The backlog in ADR is not caused by insurers or claimants. Both groups want quick resolution to these cases. A large number of claims are driven by collateral stakeholders such as health providers, paralegals and lawyers. It is these groups that have an economic interest in moving the cases into mediated negotiation, an interest that might not be shared by the accident victim.

The system is too often being used for things it was not designed for. Often it serves as a collection mechanism for health service providers who have built an industry on provision of services to auto accident victims, These are people who make their living off the auto insurance system and are using the ADR system for their own self-interest.

Tracking of mediations would help to determine matters of frequent dispute as well as systemic issues and potential abuses. The system is in need of correction so that legitimate cases can be heard.

X. Collateral issues

Use and misuse of the SABS ADR process is a concern.

Effective reform includes looking at a number of other confounding factors.

1. **Interest on overdue benefits.**

   The SABS requires interest to be paid on overdue benefits. In principle this is not offensive. But the rate of interest applied is extremely high, far higher than could ever be earned in any investment contest. Furthermore, interest on overdue SABS will pass to the recipient without taxes. The very best investment a person in our society could have is dwarfed by the monetary reward that flows from having a SABS claim that proceeds through dispute resolution very slowly. A balanced interest rate should be neutral to this consideration. An interest rate of 1% per month compounded is an incentive to dysfunction.

2. **Simplification of the benefits and the process. The benefits should be an indemnity. The amount payable should be no more than the amount of loss. To have anything other than this invites controversy, manipulation and opportunistic dishonesty.**

   The SABS process is complex to the point that it is virtually unusable. Only the most seasoned users have a chance at following the proper course in the determination of a claim. This works a great unfairness on the occasional users and drives up costs for all.

   A very large percentage of arbitration decisions are decisions about procedure, not substance. In one sample, 50% of cases were determined on procedural grounds. That this is necessary is a disgrace to a system that has lofty goals of being a consumer benefit. And the cost of devoting these resources to form, rather than substance, is a waste.

3. **Use the SABS ADR system to resolve SABS disputes. It is not designed to be, and should not be diverted for:**

   a. Making policy
   b. Supervising behaviour of regulated entities
   c. Applying penalties for regulatory non-compliance
   d. Collection of accounts by service providers
   e. Sorting out byzantine procedural mysteries.

XI. Conclusion

Although it may be unintentional, the FSCO ADR process has gone from one where there was an expectation that most cases would not reach the ADR stage and that the ADR process would not be used as a tool for creating law and policy, to one

which has been overwhelmed with cases, and value judgments are being applied by arbitrators which do not correspond with the value judgments of those who drafted the regulations and specified benefits. This has resulted in considerable instability and uncertainty, which has recently pushed the system toward its breaking point due to an in ability to rectify the various statutory and regulatory positions involved.

As such, the need for a comprehensive reform strategy in the FSCO ADR process is clear and pertinent. The system is currently operating under an unprecedented volume of cases. Without reform, the system will continue to be rife with inconsistencies, complexity and inefficiency in both time and cost, resulting in the inevitable effect that it will be unable to provide the basic service it was created to deliver. Action to implement such reform should be taken at the earliest opportunity.

In sum, the key recommendations for a comprehensive reform strategy are as follows:

1. Privatize ADR mediation and arbitration services so as to address the current service level issues;
2. Employ a Medical Expert Panel with the mandate of creating a benchmark and educating arbitrators on various medical issues involved in a particular case;
3. Engage the current legislative authority to create rules so as to mitigate the variation in the way that the SABS are interpreted and applied;
4. Consolidate appeals of dispute resolution decisions to a single forum; and
5. Amend the DRPC to address and rectify various procedural deficiencies which are rampant in the FSCO ADR process.
6. Track the types of cases that proceed to mediation to determine the reasons for the increase and how to ensure only legitimate cases are being heard.