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**Re: Ontario Automobile Insurance "*Dispute Resolution System*" Review**

TD Insurance ("TDI") is pleased to participate in the Ontario Automobile Insurance Dispute Resolution System Review. TDI's comments as set out in this document reflect our desire for long term stability and affordability of automobile insurance in Ontario, for the benefit of all stakeholders in the system.

## Preamble

With roots going back to 1949, TD Insurance ("TDI") is a member of TD Bank Group ("TDFG"), the second largest financial service organization in Canada. The wide range of TD Insurance products help protect clients from the "accidents of life" including auto and home insurance, credit protection, life, health, and travel insurance.

TDI is the largest direct response insurer in Canada and the second largest auto and home insurer in Canada, with more than 2.1 million policies and more than $2.6 billion in written premiums as of December 2012. TDI employs more than 4,000 people across Canada, with offices in Ontario, Alberta, Québec, Nova Scotia and New Brunswick.

TDI conducts its business across a variety of jurisdictions and we would be pleased to draw upon our expertise and share our experience in operating with a variety of models. We are committed to working with the government to provide a healthy auto insurance environment that is efficient, affordable, cost effective and sustainable at meeting the needs of Ontarians. TDI's submissions as set out in this document reflect our desire for an effective automobile insurance system which is fair, balanced and stable.

We all agree that Ontarians deserve a secure, stable and affordable automobile insurance market. All stakeholders, including government and insurers, share a common goal for a system that achieves long term stability and affordability of the automobile insurance system for Ontario motorists. This important public policy must be addressed within a framework that is fair and balanced.

## Executive Summary

The review of the Dispute Resolution System - which must include an understanding of the overall system - must keep in mind the values implicit in having a fair, balanced and stable automobile insurance regime.

## Objective: A Balanced System

The concept of a system that is in balance implies competing interests, which pull in different directions. At its simplest level, it is the balance between benefits and costs. All stakeholders recognize the connection, and acknowledge the need to balance. But how the stakeholders would strike that balance may differ widely.
If a system is seen to be in balance, the system will be perceived to be fair. If a system is not perceived to be in balance, a negative perception may prevail. It is important to address the relationship between benefits and cost – which is not always easily achieved.

In a balanced system, mediation is:

- A step included within other legal disputes systems (Family & Civil)
- Non-confrontational
- A process which allows the claimant and insurer to control the process and outcome, which is a far better solution than letting a third party decide, whether it be an arbitrator, judge, or jury.

## Mandatory mediation is good public policy. Why isn't it working for Ontario insurance?

- The main mandate of the mediation – to provide "just, quick and the least expensive resolution" by acting on a mediation request within 60 days – has not been consistently fulfilled. This is due, in part, to increase in claims by 14%, while there has been a decrease in car accidents; increase in mediations in 2010 prior to Government's legislative reform; and court decision that claimants may proceed to litigation/arbitration if mediation is not held in 60 days.

- The insured claimant is not consistently required to be to be active during the mediation process. Active participation will allow the claimant to be aware of the claims advanced and what is said on their behalf.

- There needs to be a change in focus to getting people better as opposed to cash for treatment option. If there is a connection between the claimant and the process, both parties will have the opportunity to actually resolve the issue and be a part of the discussion.

## Arbitration: Opportunities to improve the second step in the dispute resolution delivery model.

- Accident benefit disputes should be resolved by Arbitration as it represents a quicker, less expensive and less formal means of resolving disputes which is presently favoured by over 70% of claimants

- Arbitrations could be heard by an alternative tribunal such as the Worker's Compensation Board.

- The Standard of Judicial Review for accident benefit disputes should be determined on the "correctness" standard rather than on the "reasonableness standard".

Our submission with respect to Ontario's Dispute Resolution System will address the following areas in detail:

- Mediation Model
- Arbitration / Litigation Model
- Appeal Model
- Substantive Law

## A. Mediation

The mandate of the Dispute Resolution Group ("DRS") of the Financial Services Commission of Ontario ("FSCO") is to provide a "just, quick and the least expensive resolution" of a statutory accident benefit dispute involving claimants and insurance companies. In line with this mandate, the legislation requires Claimants (insured persons) and insurance companies to participate in a mandatory mediation with a FSCO mediator prior to a Claimant being permitted to elect to proceed to either a FSCO Arbitration or litigation in the court system to resolve the dispute.

Mediation services are free for claimants, and insurance companies pay $500. Upon receipt of the Application for Mediation, mediation is to take place within 60 days. The intent of requiring mediations prior to litigation or arbitration is to resolve disputes quickly and efficiently without the high cost and substantial time associated with the litigation or arbitration process.
Unfortunately, that mandate has not been consistently fulfilled, in part due to the following:

### *i. Claims rose 14%, but car accidents decrease*

Ontario automobile insurance claim costs are higher than any other Province in Canada. In five years between 2005 and 2010, claims costs increased by 61% from $5.4 billion to $8.7 billion. This increase represents approximately $450 per registered vehicle in Ontario.

From 2005 to 2010, the average Statutory Accident Benefit ("SABS") claim cost rose 92% from $29,189 to $56,092. Ontario's claims cost of $56,092 is more than five times higher than the average claim in other provinces[1]. This follows the Federal Superintendant of Financial Institution's statement in 2008 that, "*in Ontario, the flat*

[1] The Ontario Auditor General, 2011 Annual Report

*premium environment is being overtaken by the inexorable rise in claims costs… with absolutely no sign of abatement.*"[1][2]

There is no correlation between the increase in claim costs and the number of personal injury collisions. During the same time that claims costs rose 92%, and the number of SABS claims rose by 14%, the number of car accidents actually decreased by 3,500.[3]

In 2006 there were between 10,000 and 15,000 applications for mediation filed. Despite the drop in actual motor vehicle accidents, by 2011 there were approximately 30,000 applications for mediation being filed.

### *ii. Increase in mediations in 2010 prior to Government's legislative reform*

It is understood that an increased number of applications for mediation which were filed by Claimants' legal representatives in advance of the Government's September 2010 legislative reform of the Ontario Accident Benefit system. This permitted the filed applications to avoid the reform legislation, and be addressed under the pre-existing *Statutory Accident Benefits Schedule* ("SABS"). According to Counsel Forum Minutes of Meeting dated January 28, 2011, a total of 27,843 applications for mediation were received in 2010, approximately 7,000 more than the 20,917 applications received in 2009. This, in part, lead to a mediation backlog that reached 34,000 cases at one point.[4]

### *iii. Court decision: Claimants may proceed to litigation/arbitration if mediation not held in 60 days*

Another challenge related to two decisions faced by FSCO in ( *Hurst v. Aviva*, 2012 ONCA 837 (Court of Appeal), and *Leone v. State Farm*, FSCO P12-0004 (FSCO Appeal)), which concluded that a claimant may proceed to litigation or arbitration 60 days after filing an Application for Mediation with FSCO notwithstanding that no mediation had been held. The decisions did not result in earlier access to dispute resolution, merely allowing matters to move on to litigation/arbitration did not eliminate the backlog of claims, it simply shifted the backlog from the mediation phase (where an appropriate plan had been put in place by FSCO to address the issue) to the litigation/arbitration phase with all of the ancillary legal costs.

FSCO recently announced that the mediation backlog was eliminated as of August 2013 and that mediations are now being assigned to mediators within a couple of days of receipt.

Prior to the Mediation backlog that was resolved in August 2013, according to the Dispute Resolution Services Counsel Forum's ("Counsel Forum") Minutes of Meeting dated January 28, 2011, mediations conducted at FSCO in 2010 resulted in a full

[2] Julie Dickson, Langdon Hall Property & Casualty Insurance Industry Forum, May 22 2008
[3] Ontario Auto Insurance Anti-Fraud Task Force Interim Report, December 2011
[4] *The Counsel Forum* is comprised of lawyers and legal representatives who represent claimants or insurance companies at FSCO Arbitrations. They meet on a regular basis with representatives of FSCO Dispute Resolution Services to address practices and procedure in the FSCO dispute resolution system. Minutes of the meetings are posted on the FSCO website.

settlement of the issues in dispute 62% of the time and a partial settlement 8% of the time – approximately a 70% success rate.

With respect to the Mediation model, TDI supports the following recommendations

1. **Mediations should be Mandatory**

**Recommendation:**

TDI supports the continuation of a mandatory mediation system, and recommends certain amendments to the Mediation model set out below.

**Rationale:**

From a public policy perspective, TDI supports mediation. Mediation provides for open communication and problem solving, and provides an informal opportunity to speak directly about issues of concern in a neutral and safe environment. Mediation is cost effective and simple, and allows the parties to directly affect the outcome. Mediation is encouraged in many contexts outside of statutory accident benefits, including family law, and may be considered a best practice.

The intent of requiring mediations prior to litigation or arbitration is to provide an opportunity for claimants and insurers to meet in a non-confrontational forum with the sole intent of resolving disputes. Prior to the backlog, FSCO had a 70% success rate for mediations. As a result, claimants were able to avoid the high cost and substantial time associated with the litigation or arbitration process.

As outlined in Appendix "A", the mandatory mediation system has saved millions of dollars in direct costs (Arbitration fees for claimants and insurers) and indirect costs (legal fees for claimants and insurers; interest etc.).

The result of allowing claims that may resolve in mediation, to proceed directly to arbitration or litigation, will be a substantial increase in cost for claimants and insurers. This will undermine the Government's most current reforms and the goal to reduce claim costs in order to ensure a stable automobile insurance system for all Ontarians. Ultimately these costs would be paid by Ontario consumers in the form of higher premiums.

TDI is concerned that making mediation a voluntary process – to be influenced by plaintiff lawyers and paralegals representing claimants - will significantly reduce the benefits of the dispute resolution system and add costs to the Ontario automobile insurance system.

Some claimants and claimant representatives use the dispute resolution system as a forum to negotiate a lump sum settlement of accident benefit claims. As the direct cost of Arbitration to a claimant is minimal ($100), and as most legal representatives are compensated on a contingency basis, most claimants are unlikely to have a preference whether settlement is discussed at mediation or arbitration. It is anticipated that fewer claimants would choose to participate in a voluntary mediation process.

As noted above, the cost of Arbitration versus Mediation for insurers is significant ($3000 versus $500; legal fees/cost). The net effect of a voluntary mediation process would be an increase in dispute resolution costs which would undermine the Ontario government's stated auto insurance cost and rate reduction strategy.

TDI supports the continuation of a mandatory mediation system, with the following recommendations below. In addition, the Government must ensure that FSCO is provided with the appropriate resources to continue to address the mediations which it receives within the time frames set out in the legislation.

## 2. Amendments to the current Mediation system

**Recommendation:**

TDI supports the continuation of a mandatory mediation system, and recommends the following amendments to the Mediation Model:

- Early notification to Insurers of a claimant's Application for Mediation
- Require claimants to attend mediations (except when they are physically incapable of attending as attested to by their primary attending physician)
- FSCO Publish a monthly summary of issues in mediation

**Rationale:**

- *Early notification to Insurers of a claimant's Application for Mediation*

The present Mediation system requires FSCO to provide the insurance company with a copy of the Application for Mediation only after a Mediator has been assigned to the file.

Receipt of the Application for Mediation from FSCO is often the first notice of the dispute for the insurer. In the case of the recent mediation backlog, the insurer may not receive notice of the dispute until after the mediation has been deemed failed.

TDI recommends that FSCO provide insurers with notice of the Application for Mediation when it is first received from the claimant and/or their legal representative in order that the insurers have an opportunity to review and resolve the dispute prior to the mediation.

- *Require claimants to attend mediations (except when they are physically incapable as attested by their primary attending physician)*

TDI recommends that the rules regarding mediations at FSCO be strengthened to require:

- That claimants attend mediations, except when they are physically incapable of attending as attested to by their primary attending physician;
- If not able to physically attend due to incapacity or geography, that the claimants be present and actively participate in the mediation process by telephone (or other appropriate electronic technology).

The appropriate resolution of issues and/or files increases with the full participation of both parties involved. This will also ensure that claimants are aware of all claims being advanced and all actions taken on their behalf. It also allows claimants to actively participate throughout the entire resolution process to ensure that their best interest is being represented without any potential abuse.

The procedure for the mediation process at FSCO is governed by the *Dispute Resolution Practice Code* (the "Code"). Rule 17 of the Code provides the requirement for participation in the mediation process and reads as follows:

> *PARTICIPATION IN MEDIATION*
>
> *17.1 Parties to the mediation and their representatives (if any) must participate in good faith in the mediation process and provide all relevant documents within the time frames set out in these Rules.*
>
> *17.2 The appointment of a representative does not relieve any party of the obligation to participate in the mediation, in person, by telephone or other electronic technologies, and to provide instructions to any representative in respect of any issue in dispute or settlement offers made.*
>
> *17.3 Where a party does not comply with Rules 17.1 and 17.2 the mediator may:*
> *a) Adjourn the mediation on such terms as he or she considers appropriate; or*
> *b) Report to the parties that mediation did not take place.*

Despite the wording of Rule 17, it is not unusual for represented claimants to be "available" by telephone rather than actively participating in the mediation – in other words, the insured claimants do not actually participate at all in the mediation, but the representative states to the mediator that the insured can be contacted by telephone if required by the mediator.

Generally the mediator will not require the insured claimant to actively participate. Under those circumstances, the insured claimants do not have an opportunity to actually resolve the issue, hear what is occurring, or be involved in the discussions taking place during the mediation process.

It is difficult for claimants to fully understand the evolution of their case unless they actively participate in discussions, whether by telephone or in person.

It is recommended that Rule 17.3 be amended by replacing the word "may" with the word "shall". This will require a mediator to adjourn the mediation or to report to the parties that the mediation did not take place where the insured claimant did not actually participate in the mediation process. It is recommended that the Superintendent of Insurance issue a guideline stating that participation in mediation requires active participation and not merely being "available" by telephone.

Mediation services are currently free for claimants, and insurance companies pay $500. To support this recommendation of active participation by Claimants, a refundable fee of $100 may be established for claimants to initiate mediations, which would be forfeited if they fail to attend a scheduled mediation.

- *FSCO publish a monthly summary of issues in mediation*

Publication of a monthly summary of issues in mediation will serve as an early warning of trends and sources of new cost pressures arising from the SABS.

## B. Arbitration/Litigation

After mediation is completed appropriately, pursuant to s. 281 of the Insurance *Act*, the claimant / insured (and their law firms) have the absolute right to elect the forum for adjudication of the issue in dispute. The election is either the Superior Court of Justice or a FSCO Arbitration.

The Insurance Company has no input as to the forum for adjudication.

Arbitrations are quicker, less expensive and less formal than the Court system. FSCO Arbitrators are experts who specialize in the complex area of statutory accident benefits, while most Judges are generalists who address a range of disputes from commercial litigation to real estate and everything in-between, which may include statutory accident benefit disputes. FSCO's mandate for Arbitrations is to specifically provide timely, cost-effective and fair dispute resolution services for claimants and insurance companies.

With respect to the Arbitration model, TDI supports the following recommendations:

1. *Forum for adjudication of statutory accident benefit disputes: Arbitration only*

**Recommendation:**

TDI supports a recommendation that the forum for adjudication of all statutory accident benefit issues in dispute after a failed mediation be Arbitration.

The election process should be removed from section 281 of the *Insurance Act*, such that the Superior Court of Justice is not a forum for adjudication of statutory accident benefit disputes that require a "just, quick and least expensive resolution" forum.

**Rationale:**

Section 281 of the *Insurance Act* provides the insured person with the election to either bring a proceeding in court or refer issues in dispute to arbitration after a failed mediation with respect to an accident benefit claim.

FSCO recently advised that currently 72% of failed mediations proceed to Arbitration at FSCO. The Arbitration process is an effective system which can specifically meet and provide for appropriate cost efficient resolution of statutory accident benefit disputes in a timely manner.

Litigation, by comparison, is more costly for both claimants and insurers and resolution of a claim in litigation may take many years, involving examinations for discovery and other procedural steps. At present, parties have to wait for two or more years in Toronto

for a trial expected to last many weeks. It is not surprising that, historically, less than 2% of cases actually go to trial.

TDI recommends that section 281 of the *Insurance Act* be amended to require that all accident benefit disputes be referred to Arbitration. The advantages of this amendment include the following:

- Adjudication of statutory accident benefits disputes that require a "just, quick and least expensive resolution" forum. This includes substantial savings in legal fees for both claimants and insurers as a result of the efficiencies of the FSCO Dispute Resolution process;
- Accident Benefit disputes would be determined by an Arbitrator with expertise in interpreting the *Statutory Accident Benefits Schedule* (SABS); and
- Improved allocation of limited Court resources for other litigants due to the allocation of statutory accident benefit disputes to specialized Arbitration.

The proposed system would be similar to the system for workers in industries covered by Worker's Compensation legislation who are required to have their claims for injuries arising out of workplace accidents adjudicated by an administrative tribunal (ie. the Workplace Safety and Insurance Board ("WSIB")) rather than the courts. Appeals from decisions of the WSIB are heard by the Workplace Safety and Insurance Appeals Tribunal ("WSIAT"). WSIB claims are adjudicated upon by specialized tribunals with the requisite expertise and access to technical information required to make a fair judgment.

As noted above, 72% of claimants currently choose to refer accident benefit disputes to Arbitration rather than commence a litigation proceeding. Of those claimants who do elect to bring a litigation proceeding, less than 2% will actually result in a trial taking place. The adjudication of statutory accident benefit disputes before an expert Arbitrator that is statutorily required to provide a "just, quick and least expensive resolution" is a substantial judicial benefit. The disputes are adjudicated by an expert, and reduces reliance and overutilization of an already overburdened Court system with heavy caseloads.

### *2. FSCO Arbitration vs. Alternative Arbitration Tribunal*

**Recommendation:**

TDI supports a recommendation that the Ontario Government explore the option of statutory accident benefit disputes being adjudicated by the Workers Compensation Board, with appeals being heard by the Worker's Compensation Appeals Tribunal.

**Rationale:**

FSCO is in a unique position of being both the Regulator of the insurance industry and involved in the adjudication of statutory accident benefit disputes between insured persons and insurance companies.

The advantage of using FSCO mediators and arbitrators in the dispute resolution process is that they have developed an expertise in the interpretation and application of

the SABS. That expertise, however, could be transferred to, and/or developed at, the new Tribunal.

Queries have arisen by persons both inside and outside the dispute resolution system as to alternative independent administrative tribunals to adjudicate statutory accident benefit disputes. Other Provinces of Canada have set up independent tribunals to adjudicate accident benefit disputes. For example, Saskatchewan set up the Automobile Injury Insurance Commission to adjudicate accident benefits disputes. In Quebec, on the other hand, accident benefit dispute are adjudicated upon by Administrative Tribunal of Quebec, a body which also adjudicates other types of issues.

TDI supports the recommendation that the Ontario Government explore the option of having accident benefit disputes adjudicated by an alternative administrative tribunal, such as the Workers Compensation Board with appeals being heard by the Worker's Compensation Appeals Tribunal. The advantages of using the WSIB and WSIAT are that an infrastructure is already in place for the processing of disputes and the panel members of those Tribunals have developed an expertise in adjudicating injury and disability claims.

TD Insurance appreciates the opportunity to provide a big picture outline with respect to this potential policy option. If the Government should decide to explore this scenario in more detail, TDI would appreciate the opportunity to be part of this dialogue and respectfully requests the opportunity to provide written comments directed to the specific questions and issues that may be identified for discussion. Thank you for allowing us to provide some general input from a big picture perspective at this point in time.

**3.** *Arbitration Costs*

**Recommendation:**

TDI recommends an amendment to Rule 75 of the Dispute Resolution Practice Code (Expense Regulation) to provide that costs awarded following the hearing of an arbitration be results-based to the successful party, unless there are good reasons not to award expenses.

**Rationale:**

Rule 75 of the *Dispute Resolution Practice Code* provides that an Arbitrator may only consider the following when assessing whether or not to award expenses of Arbitration to either the Applicant or the Insurance Company:

> *75. Award of expenses*
>
> *75.1 An adjudicator may award expenses to a party if the adjudicator is satisfied that the award is justified having regard to the criteria set out in Rule 75.2. The items and amounts which may be awarded are found in Rule 78 and the Schedule to the Expense Regulation found in Section F of the Code.*

*75.2 The adjudicator will consider only the criteria referred to in the Expense Regulation found in Section F of the Code. These criteria are:*

*(a) Each party's degree of success in the outcome of the proceeding;*

*(b) Any written offers to settle made in accordance with Rule 76;*

*(c) Whether novel issues are raised in the proceeding;*

*(d) the conduct of a party or a party's representative that tended to prolong, obstruct or hinder the proceeding, including a failure to comply with undertakings and orders;*

*(e) Whether any aspect of the proceeding was improper, vexatious or unnecessary.*

*(f) whether the insured person refused or failed to submit to an examination as required under section 42 of Ontario Regulation 403/96 (Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996) made under the Act or refused or failed to provide any material required to be provided by subsection 42 (10) of that regulation; and*

*(g) whether the insured person refused or failed to submit to an examination as required under section 44 of Ontario Regulation 34/10 (Statutory Accident Benefits Schedule — Effective September 1, 2010), made under the Act, or refused or failed to provide any material required to be provided under subsection 44 (9) of that regulation.*

One of the objectives of the section is to avoid unnecessary arbitrations, and support offers to settle. Costs are consistently awarded to claimants when successful on arbitration, and even on occasion when not successful. While the wording of Rule 75 suggests that expenses may be awarded to the successful party in the arbitration, whether that party is the claimant or the insurance company, an analysis of FSCO Arbitration decisions may suggest otherwise. In practice, arbitrators award expenses to successful applicants, but may only consistently award expenses to insurance companies at a reduced scale, or where evidence of fraud is submitted or the applicant fails to appear at the arbitration. In some cases where the insurer has been successful in the arbitration, arbitrators have ruled that both parties bear their own expenses.

An example of this is the decision in *Mahjourian and TD Home and Auto Insurance Company* (2010) (FSCO A08 – 001115). In this decision, the Arbitrator ruled that the claimant was precluded from applying for and receiving statutory accident benefits under subsection 59(2) of the Schedule because she elected to bring an action referred to in section 30 of the *Workplace Safety and Insurance Act, 1997*, and that election was made primarily for the purpose of claiming benefits under the Schedule.

While acknowledging that the insurance company had been entirely successful and that he had made “negative findings about the credibility of Ms. Mahjourian’s evidence” the

Arbitrator held that he could find “no compelling reasons” to award expenses to the insurer.

The Arbitrator quoted the following statement of Arbitrator Killoran in her decision in *Shreet and RBC General Insurance Company,* in support of his ruling: *“The statute and its regulations must be interpreted in a purposive fashion which gives meaning to the remedial nature of the legislation. In this context, the Expense Regulation must be interpreted in such a way as to uphold both the protective and remedial nature of the legislation from which it flows. While changes to the Expense Regulation have moved toward a more results based approach to expenses, the approach cannot be entirely results based or the legislative purpose of the Insurance Act could be undermined*

As a result of decisions such as these, there is little downside risk to a claimant in advancing a claim with little merit. Insurers begin to question whether files that should be defended, be settled on an economic basis in order to avoid costs. Claimant representatives are aware of how to leverage the economic costs of the FSCO arbitration system to encourage settlements, or higher settlements. Claimant’s representatives are aware that, in the event that a claimant applies for arbitration at FSCO, the insurer will be billed $3000 for the Arbitration fee and incur legal costs in defending the arbitration. Claimant’s representatives use this information and refuse to compromise on disputed benefit claims particularly where the amount in dispute is less than $3000. In addition, some counsel will refuse to settle at mediation unless legal costs are paid as part of the settlement. At law, an applicant is not entitled to receive costs in the event that a dispute is settled at mediation. Accordingly, if costs are not paid, the mediation is failed and then Arbitration applied for at which time a settlement can be reached at a time in which a claimant may legally be entitled to reimbursement for costs. There is little downside to the claimant given that the Arbitration fee charged to the claimant is $100 which can be claimed from the insurer as part of the settlement.

TDI supports a recommendation that Rule 75 and the Expense Regulation be amended to provide that costs awarded following the hearing of an arbitration be results based to the successful party, unless there are good reasons not to award expenses.

**4.** *Arbitration Application Fee*

**Recommendation:**

Increase the arbitration fee for claimants from $100 to $300.

**Rationale:**

Recommended as a deterrent to over utilization and as an incentive for earlier discussions of resolution. Ease of access to the system and the perception of high payouts from success in dispute resolution have led to over utilization. The current fee has not changed since 1995.

## C. Appeals and Judicial Review

### i Current System of Appeals within FSCO

Appeals within the FSCO Dispute Resolution system are from the Arbitrator to the Director of Arbitrations. Appeals are on questions of law (s. 283(5) Insurance Act).

On appeal from a FSCO Arbitration, the Director "may confirm, vary or rescind the order appealed from or substitute his or her order for that of the arbitrator" (s. 283(1) Insurance Act).

Pursuant to s. 20 of the Insurance Act, a "privative clause", FSCO arbitrators and Directors on appeal have exclusive jurisdiction to exercise the powers conferred upon them under the Act to determine all questions of fact or law, and their decisions are final and conclusive for all purposes.

As recognized by Director Draper, FSCO arbitrators perform a decision-making function at the judicial end of the administrative law spectrum. They serve as an alternative to the courts, deciding issues that can equally be taken to the Superior Court of Justice (*Liberty Mutual and Persofsky*, Appeal P00-00041, January 31, 2003).

### ii. Current System of Judicial Review to Court

All appeal decisions of the FSCO Director can be reviewed by the Divisional Court by way of judicial review.

Due to the current privative clause in the Insurance Act, the standard of review by the Divisional Court of FSCO Arbitrators/Director's legal decisions (on questions of law) have been held to be on a "reasonableness standard of review", although on occasion also on a "correctness standard of review".

**Recommendation:**

TDI recommends that the Privative clause (s. 20 Insurance Act) be amended, or a provision be specifically inserted in the *Insurance Act*, to permit judicial review by the Divisional Court (and Court of Appeal as applicable) on a "correctness standard of review" in respect to FSCO Arbitrators/Director's legal decisions on questions of law.

**Rationale:**

As recognized by Director Draper, FSCO arbitrators perform a decision-making function at the judicial end of the administrative law spectrum (*Liberty Mutual and Persofsky*, Appeal P00-00041, January 31, 2003). The parties attending before FSCO Arbitrations or appeals should expect the triers of fact to be "correct" on questions of law, and that if not that the decision can be reviewed appropriately by the Courts.

The Supreme Court of Canada has recognized that there is great diversity of administrative boards or Tribunals. Those that are "primarily adjudicative in their functions will be expected to comply with the standard applicable to courts" – namely

correctness. (*Newfoundland Telephone Company v. Newfoundland* (Board of Commissioners Public Utilities), [1992] 1 S.C.R. 663, at pg. 638); *2747-3174 Quebec Inc. v. Quebec* (regie-des permis D'alcool) [1996], 3 S.C.R. 919, at 941 – 942, 949; [citing Minister of National Revenue v. Coopers & Lybrand, [1979] 1 S.C.R. 495, at 504 – 505); *Canadian Pacific Ltd. v. Matsqui Indian Band*, [1995] 1 S.C.R. 3, at 25).

It would appear appropriate that when there is a question of law involved in a review of the Director/Arbitrator under this statutory scheme it might be desirable to impose a standard of correctness in the interest of consistency in the administration of benefits under the schedule (*Luu v. Zurich Insurance Co* (1997), 32 O.R. (3d) 807, para. 10-11 (Ont. Div. Ct.)). If the standard of review by the Director on questions of law is correctness, this reasonably should be the standard on judicial review on questions of law.

The purpose of judicial review is to uphold the normative legal order by ensuring that the decisions of administrative decision makers are both procedurally sound and substantively defensible. The two touchstones of judicial review are legislative intent and the rule of law[5].

TDI supports a recommendations that the Privative clause (s. 20 Insurance Act) be amended, or a provision be specifically inserted in the *Insurance Act*, to permit judicial review by the Divisional Court (and Court of Appeal as applicable) on a "correctness standard of review" in respect to FSCO Arbitrators/Director's legal decisions on questions of law.

## D. Substantive Law Changes

While TDI appreciates that the mandate of the Review is not to recommend changes in the substantive law regarding accident benefit claims, the following substantive law changes would have a positive impact on the dispute resolution system.

- *Restriction on Settlement of Medical and Rehabilitation Claims*

**Recommendation:**

TDI recommends that a restriction be implemented to limit the ability to negotiate a cash settlement for medical benefit claims. The Settlement Regulation may be amended to include a two year restriction on the lump sum settlement of claims for medical benefits. The restriction could be implemented, for example, by potentially amending clause 10 of section 9.1 of O.Reg 664, RRO 1990 to read as follows:

> 10. A restriction on an insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order under sections 280 to 284 of the Act is not void under subsection 279 (2) of the Act if,
>
> (a) the restriction is contained in a settlement;

[5] *Toronto (City) v. C.U.P.E., Local 79*, [2003] 1 S.C.R. 247, para. 128 (SCC – Label J.)).

(b) the settlement of any benefits on a full an final basis not including settlement of medical and rehabilitation benefits entered into on or after the first anniversary of the day of the accident that gave rise to the claim; or after the second anniversary in the case of a full and final settlement of any medical and rehabilitation benefits; and ; and

(c) the insurer complied with subsections (2) and (3).

**Rationale:**

The Ontario accident benefit system includes a generous system of medical and rehabilitation benefits to ensure that claimants receive necessary medical treatment for injuries sustained in motor vehicle accidents. From a public policy perspective, TDI supports medical and rehabilitation benefits being utilized for actual treatment, rather than settlement monies ultimately funding lawyer contingency fees or other non-health related purposes.

However, in Ontario there has developed a "cash-for-treatment" dispute resolution system which is unique among Canadian jurisdictions. Some claimants and claimant's representatives view an accident benefit claim as an opportunity to negotiate a lump sum cash settlement in exchange for a release of benefit claims. The potential claims raised during negotiation may include treatment which has never been taken or requested by the claimant. The lump sum cash settlements do little to deliver reasonable and necessary treatment to claimants who require it. A cash settlement does not mean that the money will be used for medical treatment or rehabilitation by the claimant, and ultimately if required at a future point in time the claimant may be looking to access the public health care system for the treatment that the settlement monies represented.

An attempt was made by the Ontario government to address this issue with the amendment of the Settlement Regulation, RRO 1990, Reg. 664, section 9.1 to restrict the ability of claimants and insurers to settle accident benefit claims until after the first anniversary of the accident. While the amendment was a good idea, the recent delays in the dispute resolution system have lessened its effectiveness.

The advantage of implementing a two year restriction on the settlement of claims for medical benefits is that it will ensure that payments made for medical benefits will be used for treatment and/or medical goods.

- *Introduction of an Interpretation Guideline for the Definition of "Incurred".*

The Ontario Government introduced reforms to the SABS in September 2010 designed to reduce accident benefit claims costs. The reforms included introduction of the *Minor Injury Guideline* and introduced a definition of "incurred" in clause 3(7)(e) of the SABS which reads as follows:

> *(e) Subject to subsection (8), an expense in respect of goods or services referred to in this Regulation is not incurred by an insured person unless,*
>
> *(i) The insured person has received the goods or services to which the expense relates,*

*(ii) The insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and*

*(iii) The person who provided the goods or services,*
*(A) Did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or*
*(B) Sustained an economic loss as a result of providing the goods or services to the insured person;*

The first decision interpreting the *Minor Injury Guideline*, S*carlett and Belair Insurance Company* (2013) (FSCO A012-001079) was recently released and, if followed by other Arbitrators, would drastically reduce the number of claims which would fall within the Guideline.

As part of his decision, the Arbitrator held that the *Minor Injury Guideline,* which was issued by the Superintendent of Insurance and incorporated by reference into the SABS, was a non-binding interpretive aid which he declined to follow.

Legal decisions have also been released which have provided a liberal interpretation of "incurred" including the Ontario Court of Appeal decision in *Henry v. Gore Mutual Insurance Company*, (2013) ONCA 480 (CanLII). The Court of Appeal accepted, in this case, that the legislative intent of the introduction of the definition of "incurred" in the 2010 SABS was to put a check on payments made to family caregivers. The Court stated as follows at paragraph 26

> *[26] I agree with the appellant that the evolution of the regulations governing payment for attendant care provided by family members and the five-year report on automobile insurance in Ontario released by FSCO shortly before SABS-2010 came into force support his argument that SABS-2010 was intended to provide a check on payments to family care-givers.*

The Court of Appeal, however, went on to hold that if a non-professional caregiver suffers any economic loss, regardless of how small, then he/she is entitled to the entire amount of attendant care benefits available in the SABS. It may have been more appropriate if the Court had limited the payment to the actual small economic loss, as opposed to the entire amount. The payment can be as much as $3,000 per month for non-catastrophic cases and $6,000 per month when the injury is deemed to be catastrophic. This decision has undermined the intention of introducing the definition of "incurred" into the SABS.

The recent budget proposal to make the Superintendent's Guidelines, incorporated by reference in the *Statutory Accident Benefits Schedule*, binding, is supported by TDI.

TDI recommends implementation of an interpretation guideline such as "Rules of Interpretation with Respect to Accident Benefits", which has recently been recommended by the IBC to FSCO, in order to ensure that the effects of the 2010 reforms are not eroded. The Rules of Interpretation should be incorporated by reference into the SABS.

- *Minor Injury Guidelines (MIG) & Late Reports*

An inappropriate tactic or issue within the Dispute Resolution system which tend to increase costs and perpetuate rather than resolve a dispute involve the MIG and late reports.

Claimant's medical advisors/Clinics appear to be challenging Minor Injury Guideline ("MIG") designations with minimal evidence of pre-existing conditions or non-MIG injuries (i.e. psychological), and then submitting new reports from treating doctors shortly before an Arbitration.

Submitting new reports from treating doctors shortly before an Arbitration (i.e. in some cases 30 days before) does not afford insurers an opportunity to consider and/or respond to under present Arbitration case law, and in many cases required to accept.. As a result, insurers are forced cannot address appropriately at a FSCO arbitration, and are exposed to increased costs on the claim for interest on unpaid benefits, $3000 arbitration fee, and the legal costs of defending an Arbitration which may have been avoided if updated medical information had been delivered at an earlier date.

It is recommended that claimants be required to provide reports timely before or at mediation at the latest. In addition, the Arbitration rules should be amended to permit insurers to respond appropriately to late reports.

## **Conclusion**

TDI appreciates the opportunity to provide comment to the *Ontario Automobile Insurance Dispute Resolution System Review*. TDI believes the preferred model should be acceptable, if not attractive, to all key stakeholders, addressing fairness, balance and stability.

We trust our comments are of assistance with respect to these important matters of public policy. We are available to answer any questions which you might have concerning our submissions, or to provide further information on specific proposed changes.

Please let us know if we can be of any further assistance as you move forward in the review process,

Sincerely,

*Carol Jardine*

Carol Jardine
Vice-President, Claims Services
TD Insurance

## Appendix "A"
## Costs Savings of Mandatory Mediation System

The direct fee for Arbitration for a claimant is $100 whereas the Arbitration fee for insurers is $3000.

For example, according to the Counsel Forum Minutes of Meeting dated January 28, 2011, a total of 27,843 Applications for Mediation were received by FSCO in a 12 month period between January and December 2010. Approximately 19,000 of those cases settled at mediation. If those cases had proceeded to arbitration, the direct cost of Arbitration fees would have been $58,900,000 (19000 x $3100). The indirect fees, assuming an average of $5,000 in legal fees/costs would have been $95,000,000.

In the absence of mediation it would appear that the impact to the Ontario automobile insurance system would have been more than $150,000,000 in costs. This number would be higher for litigation.