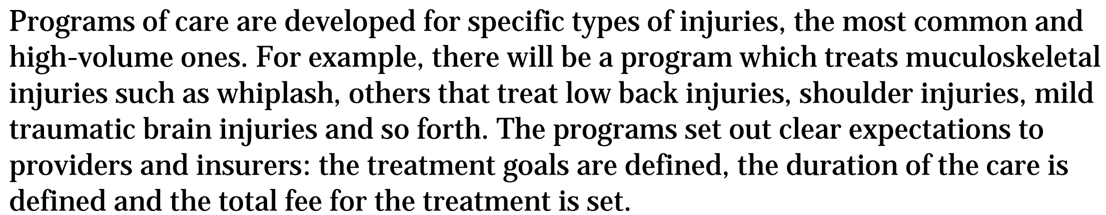


Programs of care are developed for specific types of injuries, the most common and high-volume ones. For example, there will be a program which treats muculoskeletal injuries such as whiplash, others that treat low back injuries, shoulder injuries, mild traumatic brain injuries and so forth. The programs set out clear expectations to providers and insurers: the treatment goals are defined, the duration of the care is defined and the total fee for the treatment is set.

Importantly, providers should be required to examine the patient and record their medical condition – level of pain, functionality of injured body part – prior to commencing the program and then to measure and report on the outcomes of the treatment.

Porter and Lee put it this way:

"Rapid improvement in any field requires measuring results – a familiar principle in management. Teams improve and excel by tracking progress over time and comparing their performance to that of peers inside and outside their organization. Indeed, rigorous measurement of value (outcomes and costs) is perhaps the single most important step in improving health care."[22]

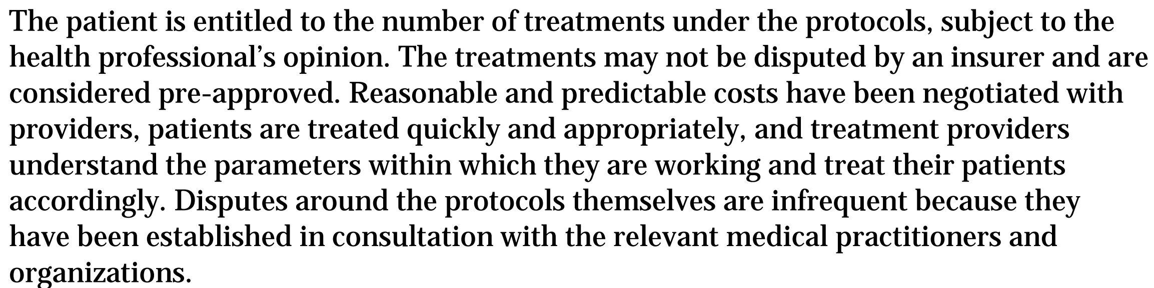
Where they are used, programs of care have been developed in consultation with the relevant professional bodies and are well understood by all providers. For example, the musculoskeletal program of care used for injured workers in Ontario was developed with the participation and contribution of regulated health professional associations, namely the Ontario Chiropractic Association, the Ontario Physiotherapy Association, the Ontario Society of Occupational Therapists and the Registered Massage Therapists' Association of Ontario.

Variations of programs of care are in use in many jurisdictions including in auto insurance delivery systems in Alberta, Nova Scotia and some states in the United States, as well as in workplace injury systems throughout Canada.

The Ontario Auto Insurance Anti-Fraud Task Force Final Report expressed the view that (well-defined) evidence-based treatment protocols could make fraudulent behaviour more difficult and made the following recommendation:

"The government should reduce uncertainty and delay for those who have legitimate auto insurance claims by moving aggressively to introduce treatment protocols for minor injuries that are based on scientific evidence."[23]

In Alberta and Nova Scotia, diagnostic treatment protocols (protocols), which are similar to programs of care, provide a structured model for the treatment of strains, sprains and whiplash injuries. The focus of the protocols is patient recovery.



The patient is entitled to the number of treatments under the protocols, subject to the health professional's opinion. The treatments may not be disputed by an insurer and are considered pre-approved. Reasonable and predictable costs have been negotiated with providers, patients are treated quickly and appropriately, and treatment providers understand the parameters within which they are working and treat their patients accordingly. Disputes around the protocols themselves are infrequent because they have been established in consultation with the relevant medical practitioners and organizations.

Under the guidance of FSCO, Ontario has already made a start along this path through the development of a Common Traffic Injury Guideline, which lays out very detailed, evidence-based treatment paths for common injuries and was designed after consultations. This work would be a good starting point from which to develop appropriate programs of care for the auto insurance industry in Ontario.

The issue of quality control of health care providers was raised more than once during my study. Professional groups of providers suggested that while most practitioners were honest and competent there exist some who are not providing appropriate care.

No doubt there will be some providers who are not meeting acceptable standards. The Ontario Auto Insurance Anti-Fraud Task Force had several suggestions to address this issue. There is a practical means of promoting good providers and dis-incenting poor providers and that is to monitor the effectiveness of treatment and the outcomes achieved. This is an essential part of the process of improving both the design and the execution of programs of care. Monitoring of provider performance also helps detect and manage fraud to the extent that it exists.

While several useful and necessary programs of care have already been developed in other systems, there is always more to be done. There are more needs that must be urgently addressed. For example, chronic pain, stress related impairment and post-traumatic stress. These medical conditions have been recognized by the courts as legitimate injuries but they are often extremely difficult to diagnose and treat. They are also a significant factor in the rising cost of benefits in the auto insurance industry. Rather than passively waiting for solutions to emerge, the insurance industry should be conducting research to develop evidence based standards for the diagnosis and treatment of mental injuries.

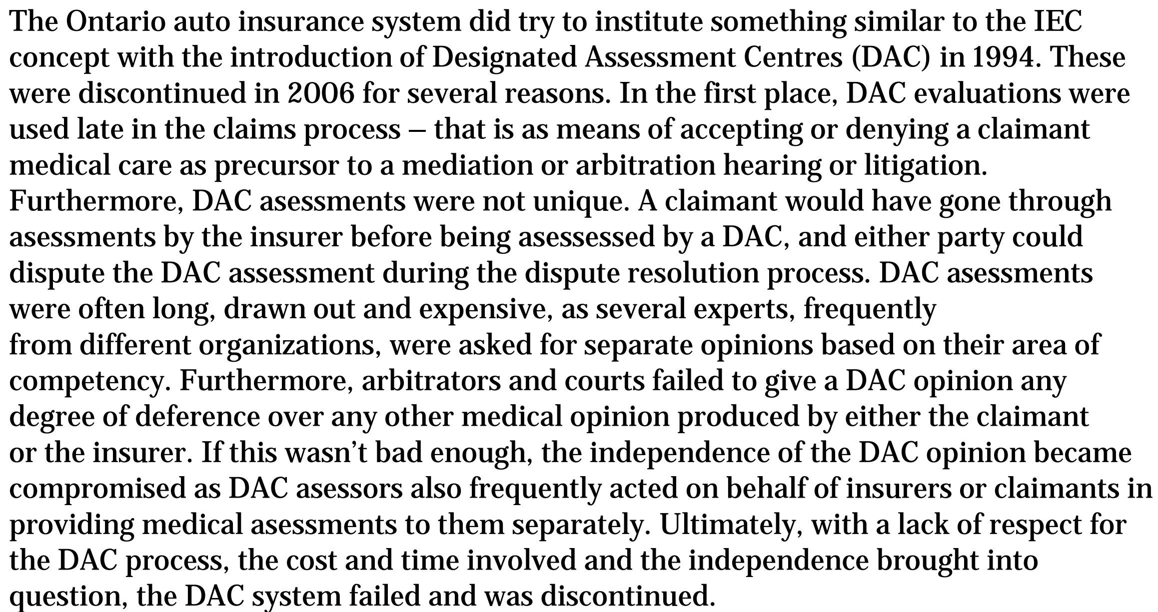
INDEPENDENT EXAMINATION CENTRE (IEC)

Both the Alberta and the Ontario Workplace Safety and Insurance Board (WSIB) systems have a process by which an injured person is referred to an independent expert where a program of care has not resulted in the full recovery of the injured person. In the WSIB system, where a program of care is not working or there is uncertainty around the appropriateness of different care programs, the patient is referred to a regional evaluation centre (not dissimilar to the independent examination centres, or IECs, defined in this report). The purpose of the referral is to provide and expert diagnosis of the present condition of the patient and to recommend future care needs.

In Ontario, the IEC would be a hospital-based service that brings multidisciplinary skills to the assessment and treatment plan for a patient. Being hospital based, physicians from multiple disciplines can be brought in to the assessment, as required. The IEC is also required to contact and have a conversation with the patient's family doctor who can provide a whole person context to the situation at hand. The role of the IEC is to examine the patient to establish a diagnosis and to provide recommendations on the best treatment options to facilitate recovery. The role of the IEC is forward looking and helpful to both the patient and the insurer in terms of the best options for future care. It is not concerned in any way with approving or denying a claim.

At WSIB, typical costs for a multi-discipline examination and treatment plan is much less expensive than the cost of medical examinations in the Ontario auto insurance system in two ways. It costs less than the $2,000 per opinion that is currently paid by the Ontario auto insurance system and the injured party does not have to submit to multiple separate examinations. As a point of reference the total cost of medical examinations paid by the WSIB in a year is about $26 million for a system handling 170,000 injury claims a year, compared with the approximately $350 million currently paid in the Ontario auto system for handling just 60,000 injury claims.[24]

To be adopted in the Ontario auto insurance system, the auto insurance regulator must keep a roster of reputable, competent, hospital-based IECs to which insurers can refer patients for assessment. The regulator would need to monitor the quality and timeliness of the advice given. Further, it is essential that the opinion of the IEC be taken as final and not subject to competing opinions from either the insurer or the patient. For this reason, it is also essential for the IEC to be a hospital-based team that can bring multidisciplinary skills to the evaluation and recommendation for treatment. Hospital-based teams already meet high medical and ethical standards. The WSIB, for example, has thirteen hospital-based centres on its roster, including Sunnybrook Health Sciences Centre and the University Health Network in Toronto, Health Sciences North in Sudbury and others located across the province. This model could be explored, as it provides an example of how the roster of IECs could be developed throughout the province.



The Ontario auto insurance system did try to institute something similar to the IEC concept with the introduction of Designated Assessment Centres (DAC) in 1994. These were discontinued in 2006 for several reasons. In the first place, DAC evaluations were used late in the claims process – that is as means of accepting or denying a claimant medical care as precursor to a mediation or arbitration hearing or litigation. Furthermore, DAC asessments were not unique. A claimant would have gone through asessments by the insurer before being asessessed by a DAC, and either party could dispute the DAC assessment during the dispute resolution process. DAC asessments were often long, drawn out and expensive, as several experts, frequently from different organizations, were asked for separate opinions based on their area of competency. Furthermore, arbitrators and courts failed to give a DAC opinion any degree of deference over any other medical opinion produced by either the claimant or the insurer. If this wasn't bad enough, the independence of the DAC opinion became compromised as DAC asessors also frequently acted on behalf of insurers or claimants in providing medical asessments to them separately. Ultimately, with a lack of respect for the DAC process, the cost and time involved and the independence brought into question, the DAC system failed and was discontinued.

In contrast, the IEC process is quite different in its purpose, its conduct and its process. An IEC evaluation takes place much earlier in the treatment cycle. It is not designed to accept or deny a claim. It is designed to provide guidance as to the best options for future care in cases where a program of care has not resulted in satisfactory recovery of the injured party. The IEC is hospital based and has access to a wide variety of medical and rehabilitation experts. In this role, the IEC is an extraordinary resource of first class expertise to aid in the treatment of the patient. IECs are also completely independent of either the insurer or the patient and they come with the quality control of a major hospital organization – their orientation and high level of competency is to provide the best possible medical advice.

In terms of the volume and intrusiveness of insurer medical exams, one of the issues with the current system is the frequency with which medical exams are sought by the insurers and claimants. As reported above, some 30,000 to 35,000 claimants per year, more than half of all claimants, are subjected to medical examinations at a cost of $9,000 for the life of the claim. Because the proposed system will be based on programs of care, there will be greater certainty around treatment and the need to dispute will be greatly reduced. Only those patients who are not responding to the programs of care will be referred to an IEC. Those referrals will not be in order to deny a claim. The IEC, in consultation with the patient's family physician, conducts an examination and makes a recommendation for additional care, where appropriate, in order to help the patient make a sound recovery.

6. The regulator should move as quickly as possible to create programs of care for the most common types of automobile injuries. The programs should be based on the evidence-based findings of the Common Traffic Injury Guidelines.

7. The regulator should be provided with a sufficient budget to monitor and continuously improve the outcomes of existing programs of care and partner with the government on research into the development of new programs of care as the need arises – for example for neurological injuries, injuries from concussions, spinal cord injuries, chronic pain and post-traumatic stress disorder. Consideration should be given to leveraging existing programs of care that have been developed by other jurisdictions.

8. The government should empower the regulator with the authority and direction to establish a roster of independent examination centres (IEC) which should be hospital-based and must be able to provide a multidisciplinary team to provide appropriate diagnoses of injured patients and recommended treatment plans. Insurers must follow, without dispute, the recommendations of the IEC for future treatment within the financial limits of the insurance policy as provided by law. The dispute resolution process must respect the evaluation of the IEC without resorting to competing opinions from either party to a dispute.

9. The regulator should conduct regular quality control studies of the outcomes of future care recommended by IECs to monitor the quality of such recommendations and ensure their effectiveness. As part of this process the regulator should consider instituting a system of professional peer review of roster asessors to ensure quality is maintained.

10. The regulator should undertake a complete overhaul of the pricing schedules for treatment by providers and evaluators to bring them more in line with prices being paid by other similar bodies, such as workers' compensation boards, and to emphasize outcomes rather than the number of treatments.

PROVIDE CARE NOT CASH

The intention of the legislation is clearly to provide accident victims the medical care they need to recover their health with some income replacement support as a bridge during the recovery period. The legislation never intended the auto insurance system to be a cash jackpot. Many insurance companies, however, are incented not to see their role as providing medical care to their clients. Rather, they are incented to close their liability with as little cash cost as possible and hence they introduce the practice of negotiating cash settlements with claimants in lieu of medical treatment, future wage loss and other future benefits under the SABS. In Cunningham's Interim Report he put it this way:

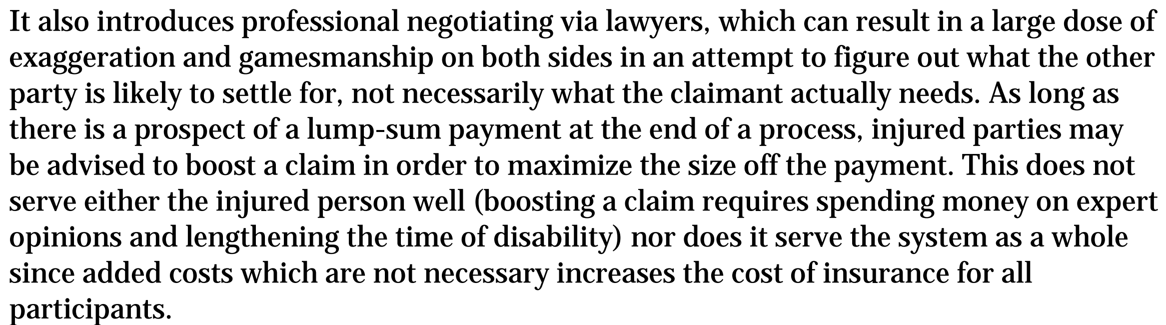
"Disputes and settlements need to be focused on getting claimants timely access to necessary treatment and assessments."

—Justice Cunningham

"Although I sympathize with the insurance industry's desire to close files on a full and final basis, I find the practice in some circumstances counter-productive. It only encourages the type of behaviour insurers have raised with me during this review. Other insurance systems such as worker's compensation or supplementary health plans will never or only in exceptional cases pay a lump sum for future health care benefits. I would support extending the one-year prohibition on settlements if it would have an impact on the 'cash for treatment' approach to care that is widely practiced. Disputes and settlements need to be focused on getting claimants timely access to necessary treatment and assessments."[25]

Justice Cunningham is referring to the practice of insurers to want to get a full and final release of the claims against them so that they can finalize their cost and release any capital that is tied up to support future amounts that might be owing on the claim. Hence insurers often drive towards getting a release on settlement of all future claims via a lump-sum payment.

This practice is counterproductive and goes against the main goal of the system which is to provide the necessary medical care and related support – not to provide a cash lump sum in lieu of care. Trying to estimate the care and other benefits needed in the future leads to lengthy negotiations over amounts which may or may not ever be put to the uses estimated.

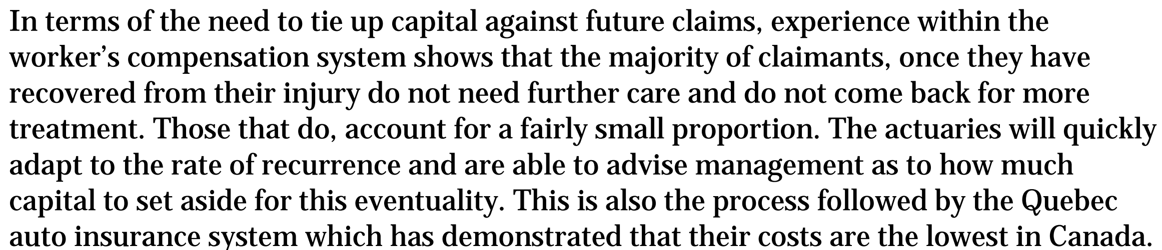


It also introduces professional negotiating via lawyers, which can result in a large dose of exaggeration and gamesmanship on both sides in an attempt to figure out what the other party is likely to settle for, not necessarily what the claimant actually needs. As long as there is a prospect of a lump-sum payment at the end of a process, injured parties may be advised to boost a claim in order to maximize the size off the payment. This does not serve either the injured person well (boosting a claim requires spending money on expert opinions and lengthening the time of disability) nor does it serve the system as a whole since added costs which are not necessary increases the cost of insurance for all participants.

To avoid this situation a major cultural shift needs to occur. As a start, insurers must stop pushing to reach full and final releases from their clients. A claim should be handled on its merits. If health care is needed it should be provided either through the programs of care mentioned above or through the diagnosis and treatment recommended by the independent examiner –within the dollar and time limits of the policy.

Once the claimant reaches medical recovery the claim is closed, but the claimant can return for more treatment – up to five years after their injury or other time limit in the legislation – if they can show that their condition has resurfaced and that it can be related to the original accident. This process has two big advantages: there is an incentive for the insurance company to stay in touch with their client to ensure they get the proper medical care so that they can return to normal function as quickly as possible; and there is no pressure to keep the claim open for long periods of time while negotiations for a release go on. The patient can come back for more treatment if that is what is fair and right.

With respect to the impact of removing a cash incentive, the study by Dr. David Cassidy et al. reported that when the Province of Saskatchewan changed its auto insurance system from a tort system where all compensation was given in cash vs. treatment to a no-fault system where treatment was provided instead of cash, the Saskatchewan system experienced a 28 per cent reduction in whiplash claims. Median time to closure of whiplash claims came down from 433 days to about 200 days. The study goes on to say that a decision to make a whiplash claim could involve factors beyond actual medical need and include a prospect of financial gain.[26] As pointed out by the Ontario Auto Insurance Anti-Fraud Task Force, the adoption of programs of care combined with the elimination of cash for care will have the effect of substantially reducing the opportunity for fraud in the system.



In terms of the need to tie up capital against future claims, experience within the worker's compensation system shows that the majority of claimants, once they have recovered from their injury do not need further care and do not come back for more treatment. Those that do, account for a fairly small proportion. The actuaries will quickly adapt to the rate of recurrence and are able to advise management as to how much capital to set aside for this eventuality. This is also the process followed by the Quebec auto insurance system which has demonstrated that their costs are the lowest in Canada.

Recommendation

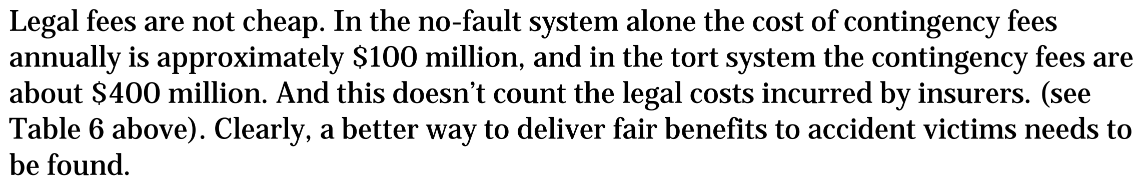
11. There should be no cash settlements in the accident benefits portion of the Ontario auto insurance system for those benefits specified in the legislation as being for medical and rehabilitation care. Where the legislation provides for cash payments, for example for lost wages and lump-sum payments for catastrophically injured persons, these would, of course, continue to be paid.

LEGAL REPRESENTATION, ADVERTISING AND CONTINGENCY FEES

> **"Money out of the pockets of claimants."**
>
> **—Justice Cunningham**

Insurance companies reported to me that about 25 to 35 per cent of claimants – some 15,000 to 20,000 a year – come to them at the time of making a claim or shortly thereafter with a lawyer already hired. From this point on, the insurance company must deal with their client only through their lawyer.

The incidence of legal representation quickly rises through the handling of the claim as difficulties arise. Going into the dispute resolution system at FSCO, there was virtually 100 per cent legal representation of clients and there is little reason to believe this situation has changed with the move of the dispute resolution system to the Licence Appeal Tribunal.



Legal fees are not cheap. In the no-fault system alone the cost of contingency fees annually is approximately $100 million, and in the tort system the contingency fees are about $400 million. And this doesn't count the legal costs incurred by insurers. (see Table 6 above). Clearly, a better way to deliver fair benefits to accident victims needs to be found.

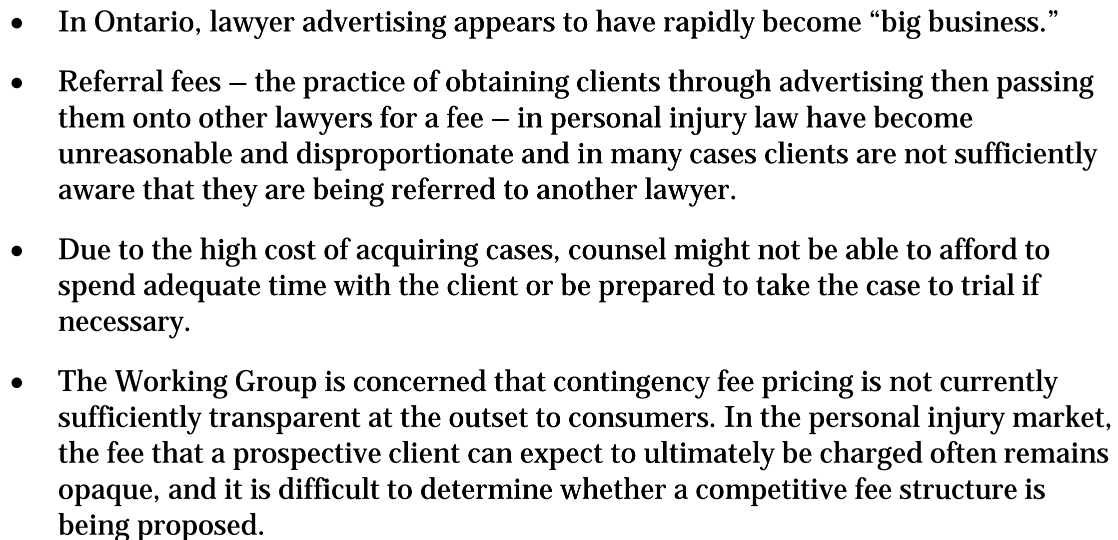
Justice Cunningham's Interim Report states:

"Ontario's auto insurance system is extremely complicated.... Not only are the SABS complicated but so are the forms required to be completed by claimants to apply for benefits or for mediation and arbitration. ... In its early days, many clients accessed the DRS without a representative. This is no longer the case. ... Legal representation is not free and not necessarily inexpensive. Legal representatives are charging SABS claimants contingency fees which I am told can be as high as 30 or 35 per cent. This is money out of the pockets of claimants who need these funds to replace lost income and pay for treatment."[27]

In many ways, the need to have lawyers involved to negotiate settlements in what should be a straightforward, no-fault, accident benefits system signals a failure in the system. The system should not be as complex as it has come to be, there should not be so much uncertainty that neither accident victims nor insurers are confident as to what constitutes fair benefits.

Many of the recommendations in this report are directed at improving this situation. The simplification of the regulations referred to in a section below; the introduction of evidence-based programs of care, delivered promptly and without dispute, an independent examination centre to guide future care if needed and strong oversight by the regulator are all measures which should greatly improve speed of access to benefits, reduce the time to recovery and reduce disputes. In the section under improvements to the tort system, the recommendation that the independent examination centre opinion on the medical condition of the accident victim and the indication of future care be given deference by the court will further improve the quality and independence of evidence provided to a court.

Contingency fees permit enhanced access to legal representation, nevertheless, it is clear that there are concerns with how the contingency fee regime is operating in Ontario auto insurance cases today. The Law Society of Upper Canada's Professional Regulation Committee (LSUC Committee) looked into the issue of advertising, contingency fees, referral fees and related matters in the practice of personal injury law. The LSUC Committee recently issued its final report which did not provide specific recommendations on contingency fees. However, in its June 23, 2016, Interim Report to Convocation, the Committee addressed Advertising and Fee Arrangements and had this to say:



- In Ontario, lawyer advertising appears to have rapidly become “big business.”
- Referral fees – the practice of obtaining clients through advertising then passing them onto other lawyers for a fee – in personal injury law have become unreasonable and disproportionate and in many cases clients are not sufficiently aware that they are being referred to another lawyer.
- Due to the high cost of acquiring cases, counsel might not be able to afford to spend adequate time with the client or be prepared to take the case to trial if necessary.
- The Working Group is concerned that contingency fee pricing is not currently sufficiently transparent at the outset to consumers. In the personal injury market, the fee that a prospective client can expect to ultimately be charged often remains opaque, and it is difficult to determine whether a competitive fee structure is being proposed.

One area of particular concern is the reported practice by some lawyers of double dipping, which is, keeping part of the legal costs awarded to clients or charging their contingency fee on top of the legal costs. Keeping the disbursements and other practices not fully explained to the client up front are either in violation of the Solicitors Act or potentially questionable.

One of the more serious and unfortunate results of the delay in finalizing claims in the Ontario auto insurance system is the burden it places on claimants when they do not receive timely assistance. Consequently, clients often suffer financial hardship. To meet this need, specialized firms called settlement loan companies step into the picture. The settlement loan companies state that the loan is on a contingency basis, promising that no credit check is necessary and no principle or interest is payable unless the client wins a settlement from the insurance company. These companies provide bridge loans to auto insurance claimants ranging from an estimated $500 to $50,000 at high interest rates. There is very little transparency on who owns these settlement loan companies, how they obtain their financing and who refers clients to them.

Handling of an accident benefits claim in a no-fault system ought to be straightforward. There should be very little, if any reason to have to hire a lawyer or resort to a finance company to provide a bridge loan, especially in cases where there are minor injuries. In the future, when the core entitlement decisions are readily determined by programs of care and neutral independent examiners, there should be little structural need for conventional litigation and a consequent improvement in both health outcomes, and the efficiency and cost of the system.

Recommendations

12. **There is clear urgency to make the accident benefits system simple and accessible without the need for legal representation. Since accident victims are in a vulnerable position and contingency-fee arrangements are not very transparent, the government should consider:**

- **Banning or restricting advertising and referral fees, and restricting contingency fees in personal injury cases, as the law society reports is being done in some jurisdictions such as in England, Wales and Australia.**
- **Requiring contingency-fee arrangements to be filed with the regulator, who should inquire into their fairness on a spot-check basis and work with the relevant authorities to curtail abuses if they arise.**
- **Settlement cheques should be made payable jointly to the accident victim and the lawyer. This will allow the accident victim to clearly understand the relationship between the total settlement and what he or she eventually receives.**
- **Claimants should be informed in writing, possibly on a final settlement schedule, of their right to appeal the fees charged by their lawyer and where to apply to do so.**

13. **The regulator should monitor the overall use of legal representation in the accident benefits system to analyze why claimants are needing to resort to legal advice. Also, the regulator should examine if the system should be further simplified, barriers should be removed or other practices changed to reduce the need for the time and expense of legal involvement.**

14. **The regulator should monitor, on a continuous basis, the length of time insurance companies are taking to provide benefits to claimants and determine if undue delays are causing financial harm to accident victims.**

Dispute Resolution

In his final report, Justice Cunningham observed:

"One of the things I quickly realized…was how polarized the system has become. I am certain that when the first no-fault auto insurance system was introduced in 1990, policy makers did not contemplate that the claims process and the [dispute resolution system] would become so adversarial. This was very much reflected in the feedback received from stakeholders. The insurance industry points to the plaintiff bar as the source of the system's problems, while the legal community blames the practices of the insurance industry. Neither is an accurate portrayal of the current system."[28]

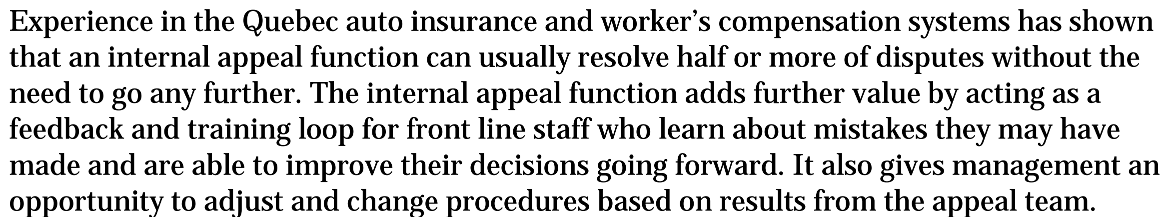
In the Ontario auto insurance system, in one out of every three cases, the insurer and the claimant cannot agree on what is a fair compensation for the injury involved. Until the Licence Appeal Tribunal began in April 2016, accident benefits disagreements were first sent to mediation and evidence shows that almost 40 per cent of the time the disagreements were not resolved at mediation and cases proceeded to arbitration (see Appendix VI). Justice Cunningham made proposals to streamline the process of mediation/arbitration and his proposals have for the most part been accepted and implemented this past year. And, while on the right path, there is more work to be done to improve the system.

The recommendations noted in earlier sections regarding introduction of programs of care, continuous care, absence of cash settlements and an independent examination centre should go a long way towards reducing disputes in the no-fault system. There should be a goal to achieve a dispute level of no more than 10 per cent compared to the current average of over 30 per cent. Later, even more challenging goals can be set.

Following Cunningham's Final Report, the dispute resolution system moved from FSCO to the Licence Appeal Tribunal of the Safety, Licensing Appeals and Standards Tribunals Ontario and many reforms were put in place.

INTERNAL APPEAL PROCESS

Justice Cunningham recommended that insurance companies set up an internal appeal process. The system of dispute resolution can be greatly helped if it becomes mandatory for insurers to have an internal appeal process. It should be staffed with case managers who have the experience and judgment to review decisions made by front line staff. The appeal team should be required to issue written decisions with explanations and support for their opinion.



Experience in the Quebec auto insurance and worker's compensation systems has shown that an internal appeal function can usually resolve half or more of disputes without the need to go any further. The internal appeal function adds further value by acting as a feedback and training loop for front line staff who learn about mistakes they may have made and are able to improve their decisions going forward. It also gives management an opportunity to adjust and change procedures based on results from the appeal team.

The auto insurance regulator should monitor the functioning of the automobile insurance dispute resolution system. For example, if a particular insurance company is generating an unusual number of appeals at the Licence Appeal Tribunal or an unusual level of reversal of their adjudicative decisions on claims, the regulator should be given the right to audit and examine the internal management and training practices of those insurers with a view to improving decision making and lowering the number of disputes going to the dispute resolution system.

GATEKEEPER FUNCTION

There is great value in establishing a gatekeeper function at the Licence Appeal Tribunal, as recommended by Justice Cunningham. More recently, a gatekeeper function has been established at the Licence Appeal Tribunal. Experience in other systems shows that this function can significantly improve the efficiency of a dispute resolution system by ensuring that claims have all the necessary documents and qualifications to proceed to examination. The gatekeeper should perform two important services.

First they must make sure that an appeal is ready to proceed, that is, all the required documents are present and all processes have been followed, which is now in place. The gatekeeper function should also insist that the claimant provide evidence of having gone through the insurer's internal appeal function before allowing the claim to proceed further.

Second, the gatekeeper must determine if new information is being introduced that has not previously been shared by either party with the other. The dispute resolution process should not become an exercise in gamesmanship or ambushing an opposing party. If there is new information that is relevant to the case it should be presented back to the original decision-maker at the insurance company or to the claimant. This might well change the decision and avoid the need to proceed any further. Only after the new information has been thoroughly considered and a new decision rendered should the appeal be allowed to proceed through the formal appeal process if necessary.

EXPERT WITNESSES

Overwhelmingly, disputes centre around or are related to the medical condition and necessary treatment of claimants. Trying to resolve this type of dispute through the process of sifting through competing expert opinions is not the most efficient or even the best way to arrive at fair conclusions. Both insurer and claimant will seek experts whose opinion is likely to support their position.

Justice Cunningham put it this way in his final report:

"Part of the culture shift that I see being needed within the Dispute Resolution System (DRS) is that medical experts appearing before adjudicators should have a duty to the DRS and not to the party that has retained them. Experts should be required to certify their duty to the tribunal and to provide fair, objective and non-partisan evidence. Arbitrators should ignore evidence that is not fair, objective or non-partisan."[29]

In order to meet the standard of objectivity and professional competence, adjudicators should be required to rely on the opinion of the independent examination centre (IEC) referred to above. IECs will be selected by the regulator who will create a roster of such centres. In the first place this serves the injured person extremely well since he or she will be getting advice from a highly qualified and independent team. Secondly, the opinion of the IEC can be relied upon, in the great majority of cases, to reflect some of the best medical thinking and techniques available.

As described earlier, the opinion of the IEC, in consultation with the family physician, must be relied upon during the management of care in the first instance that it becomes apparent that the current approach to treatment is not working. It should also be taken as final in the case of a claim going into dispute resolution. The case manager at dispute resolution may ask for a second evaluation from the roster of IECs if it appears necessary for whatever reason, but there must be no submission of competing evaluations by either the insurer or the claimant. This process would best satisfy the essential requirement that an expert witness be competent and objective and not beholden to either party in a dispute. It would also allow disputes to be handled efficiently, with less cost and with the least damage to trust in the system.

Dispute resolution in New Jersey's auto insurance system has an analogous provision. There, the arbitrator of a dispute must use a certified medical review organization as designated by the New Jersey Department of Banking and Insurance to perform a medical review of the claimant's case. The determination of the medical review organization is presumed to be correct unless the arbitrator finds the opinion to be clearly wrong, in which case he or she must provide written explanation of the reason.

Recommendations

15. **Insurers should be required to establish an internal appeal process to provide an early resolution to claims and reduce the number that have to proceed to the external dispute resolution system. The regulator should monitor the effectiveness of the internal appeal process and be empowered to order corrective action if a particular insurer is generating an unusual number of claims to the dispute resolution process.**

16. **The gatekeeper function at the Licence Appeal Tribunal should insist that a claim has gone through the insurer's internal appeal process before allowing it to proceed further. The gatekeeper should also determine that if new information is being introduced in the claim, it should go back to the original decision-maker to see if it changes the decision before the appeal proceeds.**

17. **In relation to medical condition and treatment, the opinion of the independent examination centre should be taken as definitive by arbitrators. If, in exceptional circumstances, the arbitrator has reason to be concerned about the independent examination centre opinion under consideration, the arbitrator can ask for a second opinion from a second independent examination centre from the regulator's roster. Competing examination opinions from experts hired by either the claimant or the insurer should not be permitted.**

Bringing Simplicity and Responsiveness to the System

Generally, all parties who participate in the system agree that is that the current legislation and SABS is complex and very difficult to interpret. This is surely a major contributing factor to disputes and disagreements.

The Ontario Trial Lawyers Association's (OTLA) letter to me observes:

"Those who work daily within this system have a difficult time interpreting the complex legal maze that is now Ontario auto insurance. … The ability of the average policyholder to competently manage his or her own insurance claims and related disputes is essentially non-existent. …. Both the tort and accident benefits legislation and regulations involve multiple, often incomprehensible tests for benefit and compen-sation entitlement that have led to decades of litiga-tion, at an enormous cost. As much as possible, we must eliminate those tests that lead to uncertainty and litigation."

"The ability of the average policyholder to competently manage his or her own insurance claims and related disputes is essentially non-existent."

— Ontario Trial Lawyers Association (OTLA)

Justice Cunningham put it this way:

"The SABS has become a complex and difficult document to interpret; many stakeholders noted that it is very difficult to work with it. Insurance companies need to make a considerable investment in training and developing adjusters, as does FSCO in respect to its mediators and arbitrators. Claimants need to find representatives well versed in the regulations. The learning curve associated with the SABS adds cost to the system**. Other no-fault schedules are far less complex and not so procedure-oriented** [emphasis added]. Everyone would benefit from a wholesale review of the SABS in an effort to simplify the regulation."[30]

See Appendix IV for the sections from the SABS that describe income replacement benefits, one of the main types of benefits available under the auto insurance policy. There are various procedural and definition provisions that would be relevant to a claim, but these are the main sections that set out the terms and amount of entitlement. It would take many close readings of this section to understand what the entitlement to benefits amounts to, if indeed a lay person were able to understand it at all.

There is an urgent need to address the complexity of the auto insurance regulations.

There should be well defined schedules of benefits with limited or no need for complex adjudication. The Société de l'assurance automobile du Québec (SAAQ) website offers a good example of simple, clearly understood benefits and how to access them.

The new rules should encourage the direct contact of insurers with their clients so that insurers and health care providers can work collaboratively for the health care needs of their client.

Having the regulator responsible for formulating the rules (as opposed to government amending regulations) will allow this function to respond to the need to change and evolve much more efficiently than the current structure that has to be deployed before any change can be made.

Moreover, the rules should focus on outcomes rather than process. Instead of particular forms to be used there should be a requirement to meet certain standards; for example, standards of care, standards of fair treatment, benefit of the doubt to claimants and other key components of a well-functioning system.

Recommendations

18. There is an urgent need to revise and simplify the legislation and current set of regulations and focus on desired outcomes and less on the details of process.

19. The new regulator should be given authority to make regulations (already underway). Rules should support insurers to be in direct contact with their clients so that they can manage care and recovery for their clients.

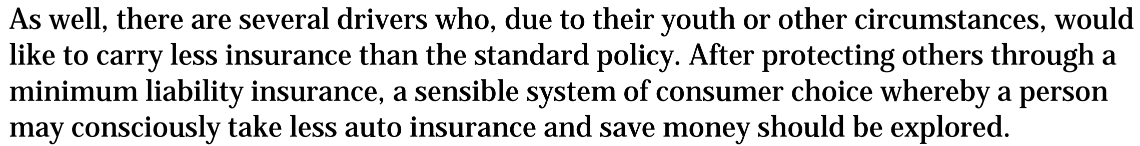
CONSUMER CHOICE – LEAVE IT TO THE MARKETPLACE…

The question of consumer choice is a difficult one to address since the auto insurance system at its heart is a safety net designed to provide needed coverage and not a suite of options based on the personal opinion of the policy holder. Consumer choice in this context usually means allowing drivers to pick a less costly coverage if they are willing to take the risk of a lower safety net. This may result in a compromise of people's safety or a lack of access to necessary treatment. On the other hand, the option to buy more coverage brings with it the need to ensure there is transparency across insurers and some confusion and lack of understanding of what is being purchased may result.

Having said that, there is a legitimate question as to how far the safety net should extend. Should the mandatory safety net cover just the most serious injuries? After all, coverage costs money. Should the government insist on coverage for catastrophic injuries and allow consumers to buy coverage for less serious injuries if they want to?

These questions lie at the heart of consumer choice. If current trendes like ridesharing are any indication, increasingly in the future, consumers will push to be allowed to tailor their purchases to their needs rather than be forced into a one size fits all product. How the government addresses this movement is of great importance. This is not the purview of this study, but it is true to say that it is an issue that is not going to go away and that the government needs to equip itself with sufficient structures and research to understand what society is likely to need in the near- and medium-term future. All of these issues should be taken into consideration as the new regulator is established.

Having said that, there are some particular cases where consumer choice can make sense. For example, according to the Canadian Life and Health Association close to 70 per cent of drivers have access to some form of medical or income replacement insurance, mostly through their workplaces, in addition to carrying auto insurance. At the same time auto insurance is a second payer – after other insurance coverages of the claimant have been used – which means that for those drivers who already have workplace insurance, they are caught between two competing insurance companies with potentially different claims processes and criteria for accepting claims. As well they must first use up their workplace insurance entitlements before they can access their auto insurance. This is a source not only of administrative complexity but also a source of surprise and frustration to claimants.



As well, there are several drivers who, due to their youth or other circumstances, would like to carry less insurance than the standard policy. After protecting others through a minimum liability insurance, a sensible system of consumer choice whereby a person may consciously take less auto insurance and save money should be explored.

At the other end of the scale, insurers should be empowered to offer additional coverages and new products if consumers are willing to pay and insurers should be encouraged to innovate and introduce new products.

Consumer choice is a powerful force that is going to change the nature of auto insurance in the not too distant future. An independent regulator held accountable for the functioning and responsiveness of the system, less prescriptive regulation, more outcome-based regulation and more flexibility on setting price should all be part of an overall regime to encourage and adopt innovation.

PROVIDING ENHANCED EDUCATION TO CONSUMERS

One of the frequent observations of stakeholders familiar with the sytem, is that consumers are generally ignorant of their insurance coverage and hence become annoyed and feel taken advantage of when it comes time to access benefits. Simplifying the regulations concering entitlements will go a long way to increasing transparency and trust.

Two actions might further improve this situation:

One consideration could be to institute an “Office of the Driver Adviser” or something similar to the proposed “Office of the Consumer” to the Financial Services Regulatory Authority. Such an office would be available to explain how auto insurance works, how to access benefits efficiently and the rights and obligations of drivers. Second, it may be useful to consider making some basic insurance concepts part of the driver education program and requirement to pass a driving test.

The Ontario Auto Insurance Anti-Fraud Task Force also had a number of good suggestions to help create an informed consumer as a protection against illegal or fraudulent practices. The task force’s final report suggested, among other things:

“With respect to *prevention*, our key recommendations include:

- “The government should join with insurers to form an Anti-Fraud Awareness Implementation Group to implement a consumer engagement and education strategy. This group should oversee the creation of:

- “educational material in different media that could instruct consumers at critical moments such as when they learn to drive, select an insurer, choose optional coverage, collide with another vehicle or make an insurance claim; and
- “a dedicated, multilingual website that would explain how to make an auto insurance claim, what to expect by way of treatment and recovery after an injury, and how to avoid, detect and report improper activity.”[31]

Recommendation

20. Consumer education in the field of auto insurance is a key component of a well-functioning system. In conjunction with making the rules and regulations governing the system simpler, the government should seriously addressthe need for enhanced consumer education. The recommendations of the Ontario Auto Insurance Anti-Fraud Task Force and the creation of an “Office of Driver Adviser” should be considered.

ENSURING GOOD FAITH

At present there are no specific rules about the consequences of false statements in the context of tort liability claims for damages. This needs to change to send a clear signal that the tort system will not be used to fuel fraudulent claims.

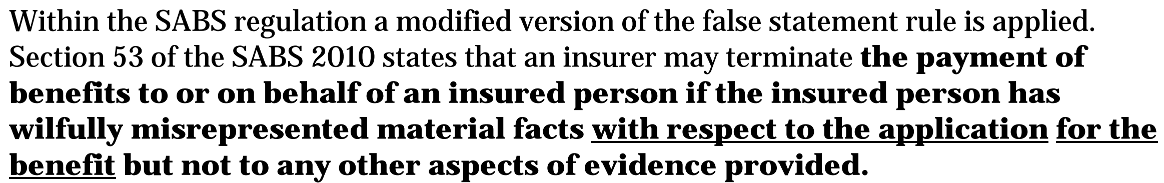
Claims under insurance policies, including claims for accident benefits are subject to provisions that apply consequences if a person makes a false statement. The logic for this is strong. Benefits administrators largely depend on the claimant’s own recitation of facts, portrayal of symptoms and assertions of impairment in order to evaluate entitlement. Assessors and adjudicators also must make decisions based on the veracity of the claimant’s own description of condition and circumstance. Much hinges on that foundation of personal credibility.

If a testimony is not reliable, then the system is deprived of the best evidence necessary to determine entitlement.

The Insurance Act recognizes the public policy of negating entitlement for dishonest claimants. Section 233 of the Insurance Act states:

> **Misrepresentation or violation of conditions renders claim invalid**
>
> **233. (1) Where,**
>
> **(a) an applicant for a contract,**
>
> **(i) gives false particulars of the described automobile to be insured to the prejudice of the insurer, or**
>
> **(ii) knowingly misrepresents or fails to disclose in the application any fact required to be stated therein;**
>
> **(b) the insured contravenes a term of the contract or commits a fraud; or**
>
> **(c) the insured wilfully makes a false statement in respect of a claim under the contract,**
>
> **a claim by the insured is invalid and the right of the insured to recover indemnity is forfeited. R.S.O. 1990, c. I.8, s. 233 (1).**
>
> **Statutory accident benefits protected**
>
> **(2) Subsection (1) does not invalidate such statutory accident benefits as are set out in the Statutory Accident Benefits Schedule. R.S.O. 1990, c. I.8, s. 233 (2); 1993, c. 10, s. 1.**

Section 233 broadly applies the false statement rule, but subsection 233(2), above, paradoxically exempts accident benefits claimants from the general rule.



Within the SABS regulation a modified version of the false statement rule is applied. Section 53 of the SABS 2010 states that an insurer may terminate **the payment of benefits to or on behalf of an insured person if the insured person has wilfully misrepresented material facts with respect to the application for the benefit but not to any other aspects of evidence provided.**

Recommendation

21. Repeal subsection 233 (2) and amend 233 (1) so that SABS claims and tort claims are subject to exactly the same rule that applies to other auto insurance claims.

IMPROVEMENTS TO THE TORT SYSTEM

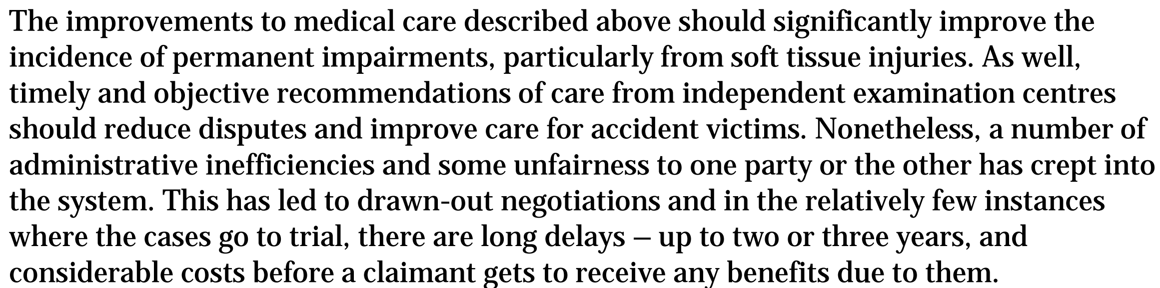
Applications for compensation under tort in Ontario accounts for a significant part of the premiums of the system – equal to or greater than the first-party, no-fault system (see Table 4 above).

The inefficiency and cost of tort claims has a large impact on the cost of the system as a whole.

The FSCO Three Year Review states that:

"Between the 2004 to the 2013 accident years, [bodily injury] claims costs for private passenger vehicles increased from approximately $1.32 billion to $2.48 billion, an increase of approximately 88 [per cent]. This is mainly due to a significant increase in the frequency of these claims."[32] While at the same time the number injuries, especially major injuries, from motor vehicle collisions was falling rapidly (see Chart 2 above). The Pinnacle Study of bodily injury claims found that the majority (67 per cent) of claimants for serious and permanent impairment had suffered soft tissue injuries – sprains and strains – at the time of the accident.

Clearly something is happening in the bodily injury portion of the system that is not being driven by changes in the number or severity of injuries. As well, it seems that the generous benefits in the no-fault portion of the system are not having the effect of reducing the amounts awarded under tort claims, while the no-fault system has itself become fraught with legal disputes and delays.



The improvements to medical care described above should significantly improve the incidence of permanent impairments, particularly from soft tissue injuries. As well, timely and objective recommendations of care from independent examination centres should reduce disputes and improve care for accident victims. Nonetheless, a number of administrative inefficiencies and some unfairness to one party or the other has crept into the system. This has led to drawn-out negotiations and in the relatively few instances where the cases go to trial, there are long delays – up to two or three years, and considerable costs before a claimant gets to receive any benefits due to them.

The current process for tort claims follows procedures in the court system developed over many years for all kinds of claims, some of which are highly complex. Auto insurance tort claims, while numerous (about 15,000 to 17,000 a year) are relatively straightforward. The issues in dispute recur frequently and seldom involve complex issues of law.

Under the current system, the basic issue of parties exchanging relevant documents and information is highly inefficient. There is no prescribed set of documents that must be produced by each party. If one party refuses to offer certain documents, the other must make a motion to the court, often a lengthy process, to compel the party to produce the documents. There is no provision for an early examination of the plaintiff or expert witnesses, which might help resolve the case before it has to go to court. As a point of comparison, the dispute resolution system at the Licence Appeal Tribunal provides for an early “case conference” to resolve issues before the case proceeds.

In the tort system, examination for discovery under oath comes much later in the litigation process and does not permit the examination under oath of expert witnesses for either side. And there is no process to encourage parties to move the case along and avoid delay.

In terms of compensation under tort, measurement of the amount and nature of future care is an area that is particularly complex and hotly contested. The opinion of an objective independent examination centre should go a long way to helping the parties to a claim come to a fair resolution of this matter. As well, amounts awarded under the no-fault system are difficult to relate to the awards made under the tort system leading to the potential for double dipping by the claimant.

As it stands today, policyholders are paying for a tort system with very little transparency as to its costs and relative benefits. And accident victims – who pay a high price for legal representation – are walking away with a lot less compensation than they ought to get. Furthermore, the tort system excludes access to drivers who are at fault, (approximately 30 per cent of accident victims). The challenge is to find the right balance between the freedom and right to sue for damages and the time and cost involved. After all it is fundamentally this reason why the no fault accident benefit system was created in the first place.

22. **The government should consider implementing ways to make the system for automobile accident tort claims more streamlined, particularly:**

- **Creating a prescribed list of documents that must be produced.**
- **Allowing for earlier examination under oath for both claimants and expert witnesses.**
- **Providing for some form of case management that encourages cases to proceed with a minimum of delay.**

23. **The regulator should monitor the awards and costs of the tort system to determine if changes need to be made to the no-fault system to avoid having to sue under tort and to recommend changes to the tort system if costs appear to outweigh benefits from a public policy point of view.**

24. **The independent examination centre's opinion as to the claimant's medical diagnosis and future care needs, should be given a zone of deference by the courts in tort cases. This means that the opinion of the independent examination centre should be taken as definitive unless there is compelling reason to doubt it.**

25. **There should be full deductibility of accident benefits awards from tort awards.**

26. **Contingency fees in tort cases should be made fully transparent to the client, including notification that fees can be appealed.**

27. **Claimants should be informed in writing, possibly on a final settlement schedule, of their right to appeal the fees charged by their lawyer.**

28. **Settlement cheques should be made payable jointly to the claimant and his or her lawyer to allow the claimant to fully understand and accept the disposition of the funds.**

INNOVATION AND PRICE REGULATION

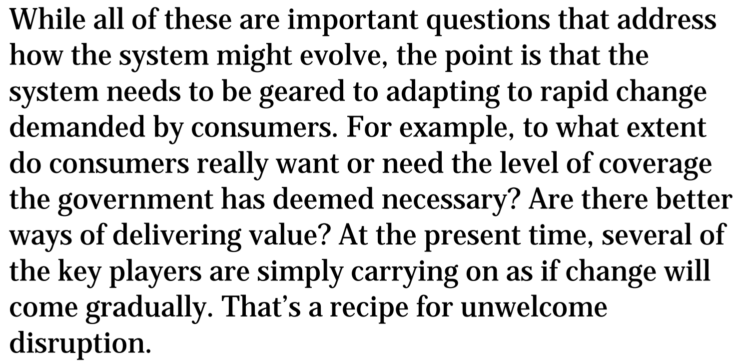
It is safe to say that in just a few years – perhaps as few as ten years - automobile insurance in Ontario will not be the same as it is today. In every part of the economy change and innovation is taking place. Traditional providers are being displaced and whole sectors of the economy are being disrupted by technology. The financial industry is no exception. Automobile insurance in Ontario, a multibillion dollar industry, is ripe for disruption.

> **Automobile insurance in Ontario will not be the same as it is today.**

In order to adapt to consumer demands, it is more than likely that auto insurers will need to merge or cooperate with players in other industries such as car manufactures, technology companies or providers of home security systems who are attempting to gain primary control over the relationship with home owners through knowledge-based monitoring of their behaviour.

It is critical that the legal and regulatory framework for the industry be so organized as to allow rapid evolution to take place in at least a rational and secure way, while continuing to protect consumers. The current framework is singularly unsuited for this role because it is not structured to be flexible and able to adapt to change.

Let us imagine one plausible disruptive scenario. A major automobile manufacturer decides to sell their cars with insurance bundled in at $400 for three years or 30,000 kilometres, whichever comes sooner. The coverage is simple, $x for medical care geared to the loss of a limb or bodily function or damage to the brain or nervous system; repair of the automobile. Part of this scenario, lifetime insurance coverage for damage and repair to the car, has already been announced by Tesla for the Asian market and by Volkswagen in Europe. It is not a stretch to find that the coverage could be extended to health care and income loss for accident victims as car manufacturers seek to find new sources of income. How will the government react? Will it try to protect the existing industry by making such an offer illegal? How will they deal with consumers who demand they be allowed to purchase such a product? How will the SABS apply? This is not a dissimilar scenario than what is being faced by the hospitality industry and the taxi industry today. To react to consumer demand, governments will have to rethink the meaning of the health care safety net incorporated into the current auto insurance product and flexibility around how it
might be delivered, as large parts of the existing regulations would likely become obsolete. The long and cumbersome premium rate setting regime will be outdated or even useless. There will be far fewer disputes and costs.



While all of these are important questions that address how the system might evolve, the point is that the system needs to be geared to adapting to rapid change demanded by consumers. For example, to what extent do consumers really want or need the level of coverage the government has deemed necessary? Are there better ways of delivering value? At the present time, several of the key players are simply carrying on as if change will come gradually. That's a recipe for unwelcome disruption.

"A ... trend away from regulation of the pricing of automobile insurance."

— FSCO Mandate Review

The system of pricing approvals today is becoming quickly outdated, time consuming and expensive. It needs to be addressed. Basically, it is a cost plus margin-for-profit system. Insurance companies present their costs and are given a margin, until recently five per cent, above their costs to set their premium. Critics have pointed to this system as being unfair to consumers since it protects insurance company profits and subsidizes inefficient providers. There are some 100 insurance companies providing auto insurance in Ontario with about 20 companies accounting for the majority of market share. Because of the built-in inertia and complexity of the rate approval process, insurers' ability to respond to market changes and take advantage of opportunities for innovation and competitiveness is reduced.

Commenting on the current rate regulation regime in Ontario, the FSCO Mandate Review expert advisory panel made the following observation:

"[There is] an international trend away from regulation of the pricing of automobile insurance while consumers seek more personalized coverage options. Many jurisdictions, particularly throughout the United States and Europe, have moved away from the prior approval system that is used to regulate auto insurance rates in Ontario. We heard from one U.S. jurisdiction that it experienced auto insurance rate reductions for nearly 80 per cent of drivers following the introduction of a more flexible system."[33]

Recommendations

29. To the extent possible, the regulatory regime should be overhauled to encourage insurers to innovate and introduce new products even on a trial or experimental basis.

30. The government should undertake a comprehensive review of auto insurance pricing alternatives with a view to providing more competition in the marketplace.

Role of the Regulator

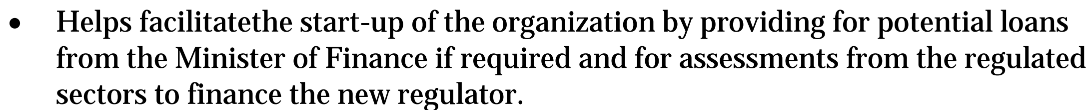
> **A new role for the insurance regulator must be constructed.**

If Ontario's system of government legislation with private sector delivery has any chance of operating well, a new role for the insurance regulator must be constructed. As discussed earlier, individual insurance companies, much less 100 of them, are in no position to, nor should they devise rules governing the delivery of insurance and the general operation of the insurance marketplace. Further, the government of the day should not be tasked with directly addressing these issues because there are more pressing big-picture issues to be addressed. In the absence of a strong central guiding force to conduct these functions, disagreement, confrontation and dysfunction are bound to prevail.

The insurance regulator in this case must take on the rule-making authority normally granted to an administrative tribunal. That is, the regulator must be an independent office and must have the authority to make policies and regulations which are binding in the field of automobile insurance. The Regulator should be responsible for the efficient and effective functioning of the auto insurance marketplace. As long as the policies and regulations set by the regulator are in keeping with the letter and spirit of the legislation, the regulator's actions should not be challenged in court.

Fortunately, the FSCO Mandate Review also recommended independent regulatory powers for the new Financial Services Regulatory Authority (FSRA). The government has accepted this advice and the FSRA Act was passed in December which, in summary:

- Establishes FSRA as a Crown agency which brings with it specific accountability requirements such as annual reports, agency business plans, and risk assessments.
- Sets out the object of FSRA to regulate the regulated sectors and requires FSRA to work with the Minister to prepare to carry out that regulatory function.
- Establishes the foundation of the governance structure for the agency by enabling the government to appoint a Board, composed of at least three and no more than 11 directors, and to designate one director as Chair.
- Specifies that the Board will govern FSRA's affairs, including appointing a CEO and making bylaws.



- Helps facilitatethe start-up of the organization by providing for potential loans from the Minister of Finance if required and for assessments from the regulated sectors to finance the new regulator.

The key next step is the appointment of the initial Board to work with the Ministry of Finance on an implementation plan.

Of particular importance in the context of automobile insurance is that the regulator, in addition to its role of consumer protection, must have its responsibilities expanded to include or enhance the following:

- Establishment of programs of care for common injuries and establishment of a roster of qualified independent examination centres. This must be a central role of the regulator. The office will need to acquire staff with medical, health care and rehabilitation expertise to ensure that medical and market practices are constantly monitored and the effectiveness of programs of care and the quality of independent examinations are monitored and adjusted as needed. If this is not done on an ongoing basis the system risks deterioration and a return to the dysfunction it is currently experiencing.
- Establishment of a roster of independent examination centres and overseeing the operation of the centres to ensure that the advice given is objective, medically sound and reasonable in the circumstances.
- Proactive analysis and monitoring of the auto insurance marketplace with changes to policies and practices being proactively promulgated. This will require statistical, analytical, medical and policy expertise to reside with the regulator.
- Conduction of research, working alongside the government, into new and emerging health care challenges such as concussions, chronic pain and post-traumatic stress.
- Monitoring the business practices of insurance companies and providers. If a particular insurance company is exhibiting an unusual number of disputes going into the Dispute Resolution process, the regulator should have the power to audit that insurer with a view to determining if claim handling or management practices are contributing to an unusual level of consumer disagreement with decisions being rendered.
- Monitoring the accident benefit, tort and dispute resolution processes to ensure that they are operating efficiently and that lessons learned are continuously translated into policy changes and improvements to benefit consumers.

The regulator should be required to set objective targets for the insurance marketplace and to report at least annually, or as regularly as seen fit by Cabinet, to the Legislature on

performance versus the targets. The targets should be set in a Memorandum of Agreement between the regulator and the Minister of Finance and should, as an illustration, include targets and improvement plans in areas such as:

- Average number of days to restore accident victims to health.
- Level and trend of accident victims acquiring permanent impairments.
- Average number and percentage of claims going to dispute resolution.
- Trend and number of benefit claims compared with automobile accidents in the province.
- Comparison of premium rates vs. other provinces.
- Average settlement costs in the no-fault and tort portions of the system, and the amount of funds going directly to medical and other needs of claimant's vs. examination, legal and other overhead costs.

Recommendations

31. A new, independent regulator with its own board of directors for automobile insurance be established either as part of the new Financial Services Regulatory Authority or a new separate office specifically for auto insurance.

32. The Insurance Act and regulations should be amended to include only broad principles and entitlements for benefits. The regulator should be responsible for interpreting the legislation and, following appropriate consultation with stakeholders, creating policies, guidelines and rules that are enforceable and not subject to challenge in the courts as long as they are in keeping with the letter and spirit of the legislation.

33. The new regulator needs to be equipped with the staff and expertise to act as a central governor over the automobile insurance marketplace including the conduct of all the players and providers within that marketplace.

34. The new regulator should be required to set standards of performance for the marketplace and to be accountable to the government for meeting those targets.

Role of Insurance Companies

Insurance companies will also have to change.

Insurers do carry a share of the blame for their reputation as being difficult to deal with. In a new system the role of insurance companies will also have to change. They must move from an approach of "closing a claim" to actually providing appropriate medical care and income support to injured parties. This after all is the fundamental intent of the legislation. During my inquiries I was surprised by how little effort, overall, the insurance companies were making to manage health care for their clients instead of managing costs. The argument they presented was that they were effectively precluded from directly helping their clients due to the presence of lawyers who acted as gatekeepers. However, a large part of their clients, more than half, did not come to the insurers with a lawyer in the first instance. I believe that insurers will need to change their mind set and approach to their clients.

Insurance companies must stop seeking to close claims via a cash settlement, something that changes the focus from health care to cash. Injured persons should be able to return for additional care as needed in accordance with the terms of the insurance policy.

Insurance companies will have to equip themselves with staff who have an appropriate level of medical and rehabilitation expertise. Their front line staff must become "case managers" rather than "claims adjusters." They need to monitor the effectiveness of health care providers and give feedback to both providers and the regulator on issues or conditions which can improve care for injured persons or remove barriers to early and efficient care.

They will need to establish an internal appeals function and they will need to monitor the reasons and outcomes of appeals and improve their management of claims accordingly.

Following a goal that is aligned directly with the intent of the legislation and focusing on the client's needs rather than on costs will yield significant results both in the value delivered to customers as well as reducing costs.

They will also need to innovate and compete on service and cost which is a role that would ensure their continued relevance and value and which most of them would welcome. The leading insurers of auto insurance, collectively represent a deep and formidable pool of talent. In a marketplace structured to take advantage of this resource, and with the right attitude, both the insurers and consumers can derive tremendous value.

Recommendation

35. Insurance companies must change their role from managing costs to delivering care to their customers. They will need to change their claims management and related practices in the process. They will also need to innovate and compete on service and cost.

AUTO SECTOR GROUPS CONSULTED

Note: Consultation does not mean endorsement. The opinions expressed in this report are entirely my own, unless they have been clearly attributed to a third party.

CONSUMERS:

Fair Association of Victims for Accident Insurance Reform (FAIR)

GOVERNMENT:

Alberta Treasury Board

Brian Jarvis, Former VP – Insurance Corporation of British Columbia

Financial Services Commission of Ontario

Florence Holden – Financial Services Tribunal

Ministry of Finance

Ministry of Health and Long-Term Care

Société de l'assurance automobile du Québec

HEALTH CARE:

Dr. Pierre Côté – University of Ontario Institute of Technology

Ontario Neurotrauma Foundation

Ontario Physiotherapy Clinic Alliance

Ontario Psychological Association Auto Insurance Subcommittee

Ontario Rehab Alliance

INSURERS:

Aviva Canada

Canadian Association of Direct Relationship Insurers

Desjardins General Insurance Group

Insurance Bureau of Canada

Intact Insurance Company (Ontario and Alberta)

The Cooperators Group

TD General Insurance Company

Travelers Canada (Ontario and Hartford)

Workplace Safety and Insurance Board

LEGAL:

Justice Douglas Cunningham

Justice Warren Winkler

Lee Samis – Samis + Samis

Ontario Trial Lawyers Association

MISCELLANOUS:

Ben Kosic – CANATICS

Holly Bakke, former New Jersey Commissioner – Department of Banking and Insurance

George Cooke – Martello Associates Consulting

Rob Sampson

Willie Handler – Willie Handler and Associates

Appendix II

CATASTROPHIC IMPAIRMENT – ONTARIO REGULATION 34/10: STATUTORY ACCIDENT BENEFITS SCHEDULE – EFFECTIVE SEPTEMBER 1, 2010

Catastrophic impairment

3.1 (1) For the purposes of this Regulation, an impairment is a catastrophic impairment if an insured person sustains the impairment in an accident that occurs on or after June 1, 2016 and the impairment results in any of the following:

1. Paraplegia or tetraplegia that meets the following criteria:

i. The insured person's neurological recovery is such that the person's permanent grade on the ASIA Impairment Scale, as published in Marino, R.J. et al., *International Standards for Neurological Classification of Spinal Cord Injury*, Journal of Spinal Cord Medicine, Volume 26, Supplement 1, Spring 2003, can be determined.

ii. The insured person's permanent grade on the ASIA Impairment Scale is or will be,

A. A, B or C, or

B. D, and

1. the insured person's score on the Spinal Cord Independence Measure, Version III, item 12 (Mobility Indoors), as published in Catz, A., Itzkovich, M., Tesio L. et al, *A multicentre international study on the Spinal Cord Independence Measure, version III: Rasch psychometric validation*, Spinal Cord (2007) 45, 275-291 and applied over a distance of up to 10 metres on an even indoor surface is 0 to 5,

2. the insured person requires urological surgical diversion, an implanted device, or intermittent or constant catheterization in order to manage a residual neuro-urological impairment, or

3. the insured person has impaired voluntary control over anorectal function that requires a bowel routine, a surgical diversion or an implanted device.

2. Severe impairment of ambulatory mobility or use of an arm, or amputation that meets one of the following criteria:

i. Trans-tibial or higher amputation of a leg.

ii. Amputation of an arm or another impairment causing the total and permanent loss of use of an arm.

iii. Severe and permanent alteration of prior structure and function involving one or both legs as a result of which the insured person's score on the Spinal Cord Independence Measure, Version III, item 12 (Mobility Indoors), as published in Catz, A., Itzkovich, M., Tesio L. et al, *A multicentre international study on the Spinal Cord Independence Measure, version III: Rasch psychometric validation*, Spinal Cord (2007) 45, 275-291 and applied over a distance of up to 10 metres on an even indoor surface is 0 to 5.

3. Loss of vision of both eyes that meets the following criteria:

i. Even with the use of corrective lenses or medication,

A. visual acuity in both eyes is 20/200 (6/60) or less as measured by the Snellen Chart or an equivalent chart, or

B. the greatest diameter of the field of vision in both eyes is 20 degrees or less.

ii. The loss of vision is not attributable to non-organic causes.

4. If the insured person was 18 years of age or older at the time of the accident, a traumatic brain injury that meets the following criteria:

i. The injury shows positive findings on a computerized axial tomography scan, a magnetic resonance imaging or any other medically recognized brain diagnostic technology indicating intracranial pathology that is a result of the accident, including, but not limited to, intracranial contusions or haemorrhages, diffuse axonal injury, cerebral edema, midline shift or pneumocephaly.

ii. When assessed in accordance with Wilson, J., Pettigrew, L. and Teasdale, G., Structured Interviews for the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale: Guidelines for Their Use, Journal of Neurotrauma, Volume 15, Number 8, 1998, the injury results in a rating of,

A. Vegetative State (VS or VS*), one month or more after the accident,

B. Upper Severe Disability (Upper SD or Upper SD*) or Lower Severe Disability (Lower SD or Lower SD*), six months or more after the accident, or

C. Lower Moderate Disability (Lower MD or Lower MD*), one year or more after the accident.

5. If the insured person was under 18 years of age at the time of the accident, a traumatic brain injury that meets one of the following criteria:

i. The insured person is accepted for admission, on an in-patient basis, to a public hospital named in a Guideline with positive findings on a computerized axial tomography scan, a magnetic resonance imaging or any other medically recognized brain diagnostic technology indicating intracranial pathology that is a result of the accident, including, but not limited to, intracranial contusions or haemorrhages, diffuse axonal injury, cerebral edema, midline shift or pneumocephaly.

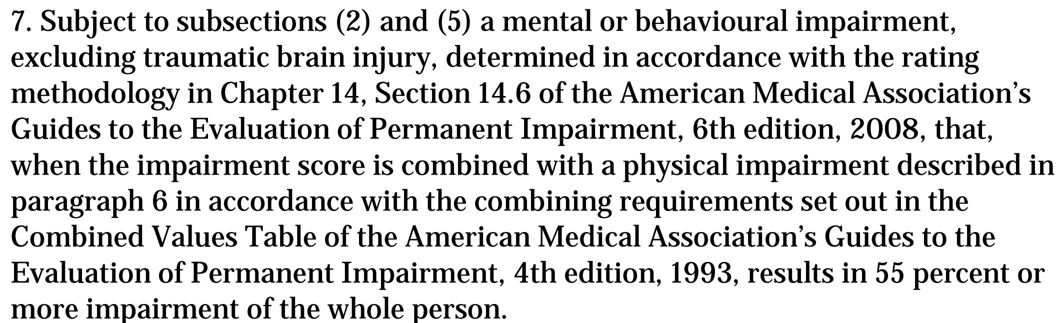
ii. The insured person is accepted for admission, on an in-patient basis, to a program of neurological rehabilitation in a paediatric rehabilitation facility that is a member of the Ontario Association of Children's Rehabilitation Services.

iii. One month or more after the accident, the insured person's level of neurological function does not exceed category 2 (Vegetative) on the King's Outcome Scale for Childhood Head Injury as published in Crouchman, M. et al, *A practical outcome scale for paediatric head injury*, Archives of Disease in Childhood, 2001: 84: 120-124.

iv. Six months or more after the accident, the insured person's level of neurological function does not exceed category 3 (Severe disability) on the King's Outcome Scale for Childhood Head Injury as published in Crouchman, M. et al, *A practical outcome scale for paediatric head injury*, Archives of Disease in Childhood, 2001: 84: 120-124.

v. Nine months or more after the accident, the insured person's level of function remains seriously impaired such that the insured person is not age-appropriately independent and requires in-person supervision or assistance for physical, cognitive or behavioural impairments for the majority of the insured person's waking day.

6. Subject to subsections (2) and (5), a physical impairment or combination of physical impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 per cent or more physical impairment of the whole person.



7. Subject to subsections (2) and (5) a mental or behavioural impairment, excluding traumatic brain injury, determined in accordance with the rating methodology in Chapter 14, Section 14.6 of the American Medical Association's Guides to the Evaluation of Permanent Impairment, 6th edition, 2008, that, when the impairment score is combined with a physical impairment described in paragraph 6 in accordance with the combining requirements set out in the Combined Values Table of the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 percent or more impairment of the whole person.

8. Subject to subsections (3) and (5), an impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993 results in a class 4 impairment (marked impairment) in three or more areas of function that precludes useful functioning or a class 5 impairment (extreme impairment) in one or more areas of function that precludes useful functioning, due to mental or behavioural disorder. O. Reg. 251/15, s. 3; O. Reg. 116/16, s. 1.

(2) Paragraphs 6 and 7 of subsection (1) do not apply in respect of an insured person who sustains an impairment as a result of an accident unless,

(a) two years have elapsed since the accident; or

(b) an assessment conducted by a physician three months or more after the accident determines that,

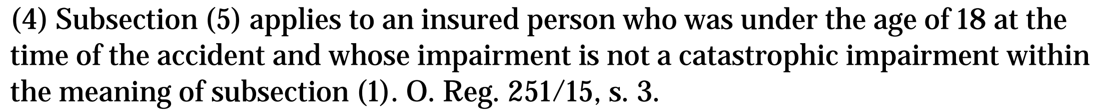
(i) the insured person has a physical impairment or combination of physical impairments determined in accordance with paragraph 6 of subsection (1), or a combination of a mental or behavioural impairment and a physical impairment determined in accordance with paragraph 7 of subsection (1) that results in 55 per cent or more impairment of the whole person, and

(ii) the insured person's condition is unlikely to improve to less than 55 per cent impairment of the whole person. O. Reg. 251/15, s. 3.

(3) Paragraph 8 of subsection (1) does not apply in respect of an insured person who sustains an impairment as a result of the accident unless,

(a) two years have elapsed since the accident; or

(b) a physician states in writing that the insured person's impairment is unlikely to improve to less than a class 4 impairment (marked impairment) in three or more areas of function that precludes useful functioning, due to mental or behavioural disorder. O. Reg. 251/15, s. 3.


(4) Subsection (5) applies to an insured person who was under the age of 18 at the time of the accident and whose impairment is not a catastrophic impairment within the meaning of subsection (1). O. Reg. 251/15, s. 3.

(5) If the insured person's impairment can reasonably be believed to be a catastrophic impairment for the purposes of paragraph 6, 7 or 8 of subsection (1), the impairment shall be deemed to be the impairment referred to in paragraph 6, 7 or 8 of subsection (1) that is most analogous to the impairment, after taking into consideration the developmental implications of the impairment. O. Reg. 251/15, s. 3.

Appendix III

EXAMINATION CLAIMS EXPERIENCE (PRIVATE PASSENGER VEHICLES) BY ACCIDENT YEAR

	2004	2009	2010	2012	2013
Number of examination claims	36,448	47,375	48,970	31,070	36,127
Number of claims per 100 insured vehicles	0.615	0.73	0.746	0.459	0.527
Accident benefits earned vehicles	5,926,718	6,492,051	6,563,999	6,774,926	6,856,005
Average cost of examinations per insured vehicle	$41.94	$130.34	$129.05	$41.74	$50.60
Total examination costs	$248.6 million	$846.2 million	$847.1 million	$282.8 million	$346.9 million
Total accident benefits claims costs	$1.60 billion	$3.81 billion	$3.78 billion	$1.92 billion	$2.15 billion

Source: 2013 General Insurance Statistical Agency exhibits for private passenger vehicles.

INCOME REPLACEMENT BENEFITS – ONTARIO REGULATION 34/10: STATUTORY ACCIDENT BENEFITS SCHEDULE – EFFECTIVE SEPTEMBER 1, 2010

Income Replacement Benefits

Interpretation

4. (1) In this Part,

"gross employment income" means salary, wages and other remuneration from employment, including fees and other remuneration for holding office, and any benefits received under the *Employment Insurance Act* (Canada), but excludes any retiring allowance within the meaning of the *Income Tax Act* (Canada) and severance pay that may be received; ("revenu brut d'emploi")

"gross weekly employment income" means, in respect of an insured person, the amount of the person's gross annual employment income, as determined under subsection (2), divided by 52; ("revenu brut hebdomadaire d'emploi")

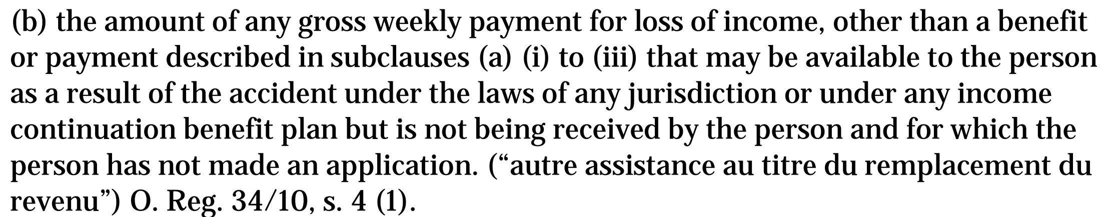
"other income replacement assistance" means, in respect of an insured person who sustains an impairment as a result of an accident,

(a) the amount of any gross weekly payment for loss of income that is received by or available to the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan, other than,

(i) a benefit under the *Employment Insurance Act* (Canada),

(ii) a payment under a sick leave plan that is available to the person but is not being received, and

(iii) a payment under a workers' compensation law or plan that is not being received by the person because the person has elected under the workers' compensation law or plan to bring an action and is not entitled to the payment, and



(b) the amount of any gross weekly payment for loss of income, other than a benefit or payment described in subclauses (a) (i) to (iii) that may be available to the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan but is not being received by the person and for which the person has not made an application. ("autre assistance au titre du remplacement du revenu") O. Reg. 34/10, s. 4 (1).

(2) The gross annual employment income of an insured person is determined as follows:

1. In the case of a person referred to in subparagraph 1 i of subsection 5 (1) who was not a self-employed person at any time during the four weeks before the accident, the person's gross annual employment income is whichever of the following amounts the person designates:

i. The person's gross employment income for the four weeks before the accident, multiplied by 13.

ii. The person's gross employment income for the 52 weeks before the accident.

2. Subject to paragraph 3, the person's gross annual employment income is his or her gross employment income for the 52 weeks before the accident if,

i. the person qualifies for a benefit under subparagraph 1 i of subsection 5 (1) and was a self-employed person at any time during the four weeks before the accident, or

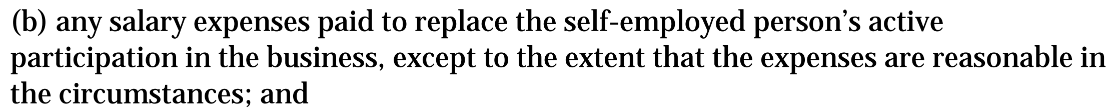
ii. the person qualifies for a benefit under subparagraph 1 ii of subsection 5 (1).

3. If the person described in subparagraph 2 i was self-employed for at least one year before the accident, the person may designate as his or her gross annual employment income the amount of his or her gross employment income during the last fiscal year of the business that ended on or before the day of the accident. O. Reg. 34/10, s. 4 (2); O. Reg. 370/10, s. 1.

(3) A self-employed person's weekly income or loss from self-employment at the time of the accident is the amount that would be 1/52 of the amount of the person's income or loss from the business for the last completed taxation year as determined in accordance with Part I of the *Income Tax Act* (Canada). O. Reg. 34/10, s. 4 (3).

(4) A self-employed person's loss from self-employment after an accident is determined in the same manner as losses from the business in which the person was self-employed would be determined under subsection 9 (2) of the *Income Tax Act* (Canada) without making any deductions for,

(a) any expenses that were not reasonable or necessary to prevent a loss of revenue;



(b) any salary expenses paid to replace the self-employed person's active participation in the business, except to the extent that the expenses are reasonable in the circumstances; and

(c) any non-salary expenses that are different in nature or greater than the non-salary expenses incurred before the accident, except to the extent that those expenses are reasonable in the circumstances and necessary to prevent or reduce any losses resulting from the accident. O. Reg. 34/10, s. 4 (4).

(5) If, under the *Income Tax Act* (Canada) or legislation of another jurisdiction that imposes a tax calculated by reference to income, a person is required to report the amount of his or her income, the person's income before an accident shall be determined for the purposes of this Part without reference to any income the person has failed to report contrary to that Act or legislation. O. Reg. 34/10, s. 4 (5).

(6) The amount of a person's gross annual employment income and the amount of the person's income or loss from self-employment may be adjusted for the purposes of this Part to reflect any subsequent change in the amount determined by the Canada Revenue Agency under the *Income Tax Act* (Canada) or by the relevant government or agency under the legislation of another jurisdiction that imposes a tax calculated by reference to income. O. Reg. 34/10, s. 4 (6).

Eligibility criteria

5. (1) The insurer shall pay an income replacement benefit to an insured person who sustains an impairment as a result of an accident if the insured person satisfies one or both of the following conditions:

1. The insured person,

   i. was employed at the time of the accident and, as a result of and within 104 weeks after the accident, suffers a substantial inability to perform the essential tasks of that employment, or

   ii. was not employed at the time of the accident but,

      A. was employed for at least 26 weeks during the 52 weeks before the accident or was receiving benefits under the *Employment Insurance Act* (Canada) at the time of the accident,

      B. was at least 16 years old or was excused from attending school under the *Education Act* at the time of the accident, and

      C. as a result of and within 104 weeks after the accident, suffers a substantial inability to perform the essential tasks of the employment in which the insured person spent the most time during the 52 weeks before the accident.

2. The insured person,

i. was a self-employed person at the time of the accident, and

ii. suffers, as a result of and within 104 weeks after the accident, a substantial inability to perform the essential tasks of his or her self-employment. O. Reg. 34/10, s. 5 (1).

(2) Despite subsection (1), an insured person is not eligible to receive income replacement benefits if he or she is eligible to receive and has elected under section 35 to receive either a non-earner benefit or a caregiver benefit under this Part. O. Reg. 34/10, s. 5 (2).

Period of benefit

6. (1) Subject to subsection (2), an income replacement benefit is payable for the period in which the insured person suffers a substantial inability to perform the essential tasks of his or her employment or self-employment. O. Reg. 34/10, s. 6 (1).

(2) The insurer is not required to pay an income replacement benefit,

(a) for the first week of the disability; or

(b) after the first 104 weeks of disability, unless, as a result of the accident, the insured person is suffering a complete inability to engage in any employment or self-employment for which he or she is reasonably suited by education, training or experience. O. Reg. 34/10, s. 6 (2).

Amount of weekly income replacement benefit

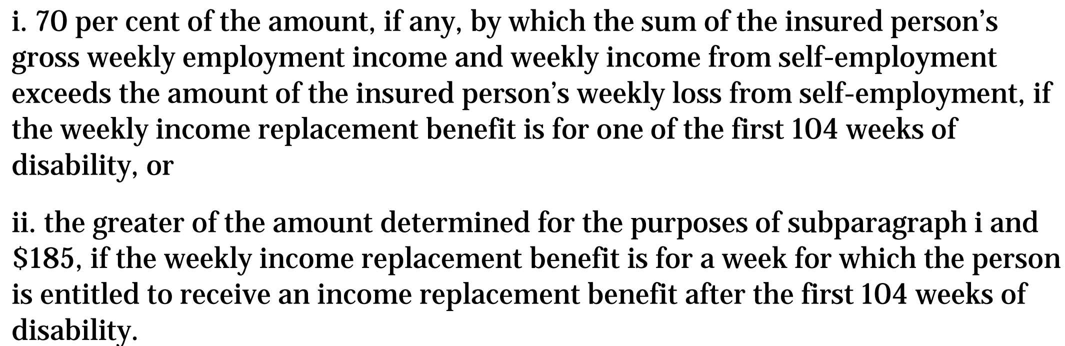
7. (1) The weekly amount of an income replacement benefit payable to an insured person who becomes entitled to the benefit before his or her 65th birthday is the lesser of “A” and “B” where,

“A” is the weekly base amount determined under subsection (2) less the total of all other income replacement assistance, if any, for the particular week the benefit is payable, and

“B” is $400 or, if an optional income replacement benefit referred to in section 28 has been purchased and applies to the person, the amount fixed by the optional benefit. O. Reg. 34/10, s. 7 (1).

(2) For the purposes of subsection (1), the weekly base amount in respect of an insured person is determined as follows:

1. Determine whichever of the following amounts is applicable:



i. 70 per cent of the amount, if any, by which the sum of the insured person's gross weekly employment income and weekly income from self-employment exceeds the amount of the insured person's weekly loss from self-employment, if the weekly income replacement benefit is for one of the first 104 weeks of disability, or

ii. the greater of the amount determined for the purposes of subparagraph i and $185, if the weekly income replacement benefit is for a week for which the person is entitled to receive an income replacement benefit after the first 104 weeks of disability.

2. To the amount determined under paragraph 1, add 70 per cent of the amount of the insured person's weekly loss from self-employment that he or she incurs as a result of the accident. O. Reg. 34/10, s. 7 (2).

(3) The insurer may deduct from the amount of an income replacement benefit payable to an insured person,

(a) 70 per cent of any gross employment income received by the insured person as a result of being employed after the accident and during the period in which he or she is eligible to receive an income replacement benefit; and

(b) 70 per cent of any income from self-employment earned by the insured person after the accident and during the period in which he or she is eligible to receive an income replacement benefit. O. Reg. 34/10, s. 7 (3).

(4) The insurer shall pay an expense incurred by or on behalf of an insured person for the preparation of a report for the purpose of calculating the person's income from employment or self-employment if all of the following conditions are satisfied:

1. The insured person is applying for an income replacement benefit under this Part that is based on the employment or self-employment considered in the report.

2. The report is prepared by a member of a designated body within the meaning of the *Public Accounting Act, 2004.*

3. The expense is reasonable and necessary for the purpose of determining the insured person's entitlement to an income replacement benefit. O. Reg. 34/10, s. 7 (4); O. Reg. 289/10, s. 2.

(5) The insurer is not required to pay more than a total of $2,500 for the preparation of one or more reports under subsection (4) in respect of an insured person. O. Reg. 34/10, s. 7 (5).

Adjustment after age 65

8. (1) If a person is receiving an income replacement benefit immediately before his or her 65th birthday, the weekly amount of the benefit is adjusted, on the later of the day of the person's 65th birthday and the second anniversary of the day the person began receiving the benefit, to the amount determined in accordance with the following formula:

$$C \times 0.02 \times D$$

in which,

"C" is the weekly amount of the income replacement benefit that the person was entitled to receive immediately before the adjustment, before any deductions permitted by subsection 7 (3),

"D" is the lesser of,

(a) 35, and

(b) the number of years during which the person qualified for the income replacement benefit before the adjustment is made.

O. Reg. 34/10, s. 8 (1).

(2) Despite section 6, an income replacement benefit that has been adjusted under subsection (1) is payable, without any deductions under clause 7 (3) (a) or (b), until the person dies. O. Reg. 34/10, s. 8 (2).

If entitlement first arises on or after 65th birthday

9. (1) If an insured person becomes entitled to receive an income replacement benefit on or after his or her 65th birthday,

(a) subject to clause 6 (2) (a) and despite clause 6 (2) (b), the insured person is entitled to an income replacement benefit for not more than 208 weeks after becoming entitled to the benefit; and

(b) the weekly amount of the benefit is the weekly amount of the income replacement benefit otherwise determined under section 7 before any deductions permitted by subsection 7 (3), multiplied by the factor set out in Column 2 of the Table to this subsection opposite the number of weeks that have elapsed since the person became entitled to receive the benefit.

TABLE

Column 1 Number of weeks since Entitlement Arose	Column 2 Factor
Less than 52 weeks	1.0
52 weeks or more but less than 104 weeks	0.8
104 weeks or more but less than 156 weeks	0.6
156 weeks or more but less than 208 weeks	0.3

O. Reg. 34/10, s. 9 (1).

(2) No deduction may be made under clause 7 (3) (a) or (b) from an income replacement benefit determined under subsection (1). O. Reg. 34/10, s. 9 (2).

No violation of *Human Rights Code*

10. The age distinctions in sections 8 and 9 apply despite the *Human Rights Code*. O. Reg. 34/10, s. 10.

Temporary return to employment

11. A person receiving an income replacement benefit may return to or start employment or self-employment at any time during the first 104 weeks for which he or she is receiving the benefit without affecting his or her entitlement to resume receiving any benefits to which he or she is entitled under this Part if, as a result of the accident, he or she is unable to continue the employment or self-employment. O. Reg. 34/10, s. 11.

Appendix V

GENERAL INSURANCE STATISTICAL AGENCY – PRIVATE PASSENGER VEHICLES ACCIDENT BENEFITS CLAIMS FOR MEDICAL AND REHABILITATION – 2013

Breakdown of costs between Medical Care and Other

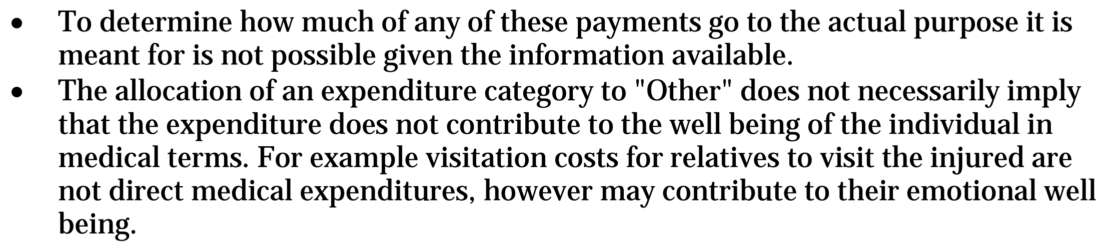
	Medical Care	Other	Medical Care %**	Other %
Medical	$898,987,620		50%	
Visitation		$4,976,449		0.28%
Dependant Care		$38,751		0%
Housekeeping		$34,685,455		2%
Examination		$335,134,533		19%
Rehab - other than renovation	$89,186,509		5%	
Renovation Rehab	$33,772,102		2%	
Attendant Care	$381,312,138		21%	
Replacement etc.*	$3,514,809		0%	
All Med/Rehab	$1,406,773,177	$374,835,188	79%	21%
Total Med/Rehab Expenditure	**$1,781,608,366**			

** Replacement of clothing, hearing aids, glasses and other devices*

*** Percentage are over total med/rehab amount*

Notes:

- This segregation of amounts is based on the definitions of the accident benefits coverages.
- When settlements are paid, insurers allocate the amounts to one of the coverages above.



- To determine how much of any of these payments go to the actual purpose it is meant for is not possible given the information available.
- The allocation of an expenditure category to "Other" does not necessarily imply that the expenditure does not contribute to the well being of the individual in medical terms. For example visitation costs for relatives to visit the injured are not direct medical expenditures, however may contribute to their emotional well being.

Appendix VI

INFORMATION SUPPLIED BY THE FINANCIAL SERVICES COMMISSION OF ONTARIO

Dispute resolution services – mediation and arbitration from 2011/12 to 2015/16

	Mediation	Arbitration
A. Total applications less admin closures	115,908	
B. Full and partial Settlements Total value of full and partial settlements Annual average	54,790 $777,400,000 $17,143	
C. Settlements with zero value	(9,523)	
D. Move to arbitration		44,599
E. Offline[34]		25,701[35]
F. Failed Settlements		61,118
G. Total	115,908	

Conclusions

A. Average number of claims going to mediation	23,200
B. Average annual settled at mediation with value >$0 a. Average annual value b. Annual average value of settlement	((B-C)/A); 39% $155,500,000 $17,143
C. Settlements with zero value (annual average / %)	2,000; (C/A) 8.2%
D. Moved to arbitration (annual average / %)	9,000; (D/A) 38%
E. Moved off line (annual average / %)	5,140; (E/A) 22%

Over a five-year period (2011-2015), the average number of applications going into mediation at FSCO annually was 23,200 (or about 35 per cent of total claims).

Declined amounts as a % of proposed amounts – OCF18[36]

	Proposed Amounts*	Declined Amounts**	Declined for Reason: Not Reasonable or Necessary	Percentage Declined
2011H1	$331,346,422	$147,703,454	$38,236,804	45%
2011H2	$321,560,134	$120,913,044	$31,386,306	38%
2012H1	$259,966,717	$91,108,386	$25,784,396	35%
2012H2	$295,848,707	$95,396,549	$28,035,888	32%
2013H1	$264,960,375	$81,626,632	$22,915,597	31%
2013H2	$317,989,691	$97,928,001	$29,145,141	31%
2014H1	$257,335,801	$73,690,588	$20,959,038	29%
2014H2	$269,959,037	$70,281,773	$18,039,737	26%
2015H1	$212,584,457	$52,652,108	$14,193,819	25%
2015H2	$185,646,061	$42,058,878	$10,173,917	23%
2016H1	$53,299,204	$13,185,308	$2,093,520	25%

Source: HCAI

Note: Later year data is still developing.

** Proposed Amounts: Sum total of all amounts proposed for treatment.*

*** Declined Amounts are for the following reasons:*

- *Diagnosis indicates that MIG is appropriate*
- *Diagnosis Is Inconsistent With The Provider Type*
- *Procedure is Inconsistent with the Diagnosis*
- *Diagnosis Is Inconsistent With The Cause of Loss*
- *Not Reasonable and Necessary*
- *Service/Product Is Inconsistent With The Cause of Loss*
- *Fee Exceeds Reasonable Fees for Product or Service*
- *Fee Exceeds Maximum Allowed*
- *Service/Procedure Time Adjustment*
- *Policy Coverage Limits Exceeded*
- *Good or service not covered*
- *There is a conflict of interest*
- *Other please provide an explanation*

Endnotes

[1] Meckbach, Greg, Canadian Underwriter, "'Lots of room for improvement' with new Ontario auto dispute resolution system: Judge Cunningham," http://www.canadianunderwriter.ca/insurance/lots-room-improvement-new-ontario-auto-dispute-resolution-system-judge-cunningham-1004102925/, November 2, 2016.

[2] Sources of data for Figure 1 (The cited General Insurance Statistical Agency data represents only transactions related to private passenger vehicles.):

a – Preliminary 2014 Ontario Road Safety Annual Report Selected Statistics, Ministry of Transportation.

b – Ontario Road Safety Annual Report 2013, Ministry of Transportation.

c – 2013 accident year, 2015 General Insurance Statistical Agency (GISA) loss ratio exhibit for private passenger vehicles. Accident benefits claims is estimated based on GISA actuarial calculations.

d – 2013 FSCO dispute resolution system data.

e – 2013 accident year data from FSCO DRS group.

f – 2013 accident year, 2015 GISA loss ratio exhibit for private passenger vehicles. Number is estimated based on GISA actuarial calculations.

g – 2013 accident year data from Ontario Health Claims Database (HCDB), September 2016 report. Please note that the assessments include both insurer initiated as well as provider initiated. A claimant could have both, however are counted once. Also note that provider initiated assessments may include a count for assessments that are offered as part of treatment.

h – 2013 annual average based on business information reported to Health Claims for Auto Insurance (HCAI).

i – Registered Insurance Brokers of Ontario, as of August 2014; not specific to Auto Insurance.

[3] Ontario Road Safety Annual Report – 2013

[4] FSCO Three Year Review, December 2014, Chart 9, p. 41, http://www.fsco.gov.on.ca/en/auto/3yr-review/Documents/aoda-3yr-review.pdf

[5] O. Reg. 34/10, s. 16 (1).

[6] Drs. Côté P., et al., Early and Aggressive Care and Delayed Recovery From Whiplash, June 15, 2007, p. 861.

[7] Cassidy, J. David et al., "Effect of Eliminating Compensation for Pain and Suffering on the outcome of Insurance Claims for Whiplash Injuries," The New England Journal of Medicine, Volume 342, Number 16, April 20, 2000, p. 1184

[8] Association of Workers' Compensation Boards of Canada Key Statistical Measures Data, 2015 http://awcbc.org/?page_id=9759&_sm_au_=iVV5R7SWWnFtj1RP

[9] Drs. Côté P., Hogg-Johnson S., Cassidy JD., Carroll L., Frank JW. in their study *Initial Patterns of Clinical Care and Recovery from Whiplash Injuries: A Population-Based Cohort Study, p. 2261.*
[10] *Automobile Insurance Third Party Liability Bodily Injury Closed Claim Study in Ontario* conducted by Pinnacle Actuarial Resources, Inc (Pinnacle Study), August 13, 2014, p. 4, https://www.fsco.gov.on.ca/en/auto/Documents/abbreviated-report.pdf
[11] FSCO Three Year Review, December 2014, Table 5, p. 40, http://www.fsco.gov.on.ca/en/auto/3yr-review/Documents/aoda-3yr-review.pdf
[12] Association of Workers' Compensation Boards of Canada Key Statistical Measures Data, 2015, http://awcbc.org/?page_id=9759&_sm_au_=iVV5R7SWWnFtj1RP
[13] Ontario Workplace Safety and Insurance Board, 2015 Economic Statement, available at www.wsib.on.ca
[14] Meckbach, Greg, Canadian Underwriter, "'Lots of room for improvement' with new Ontario auto dispute resolution system: Judge Cunningham," http://www.canadianunderwriter.ca/insurance/lots-room-improvement-new-ontario-auto-dispute-resolution-system-judge-cunningham-1004102925/, November 2, 2016.
[15] GISA Examination Claims Experience. See Appendix III.
[16] By the Numbers, Ontario Workplace Safety and Insurance Board Health Care Benefit Payments by Service Categories by Payment Year www.wsib.on.ca
[17] Cunningham, the Honourable J. Douglas, *Ontario Automobile Insurance Dispute Resolution System Review Final Report* (Cunningham Final Report), p. 6
[18] Insurance Corporation of British Columbia's financial statement
[19] Justice Cunnigham's Interim Report, p. 13
[20] Spine Journal, "Does Early Management of Whiplash-Associated Disorders Assist or Impede Recovery?", Drs. Côté P. and Soklaridis S., p. S276
[21] Porter, Michael E. and Lee, Thomas H., "The Strategy That Will Fix Health Care," Havard Business Review, October 2013.
[22] Ibid.
[23] Ontario Auto Insurance Anti-Fraud Task Force Final Report, p. 28
[24] By the Numbers, Ontario Workplace Safety and Insurance Board Health Care Benefit Payments by Service Categories by Payment Year www.wsib.on.ca
[25] Justice Cunnigham's Interim Report, p. 31
[26] Cassidy, J. David et al., "Effect of Eliminating Compensation for Pain and Suffering on the outcome of Insurance Claims for Whiplash Injuries," The New England Journal of Medicine, Volume 342, Number 16, April 20, 2000, p. 1184
[27] Justice Cunnigham's Interim Report, p. 26
[28] Justice Cunnigham's Final Report, p. 5
[29] Justice Cunnigham's Final Report, p. 23
[30] Ontario Automobile Insurance Dispute Resolution System Review Final Report, p. 14
[31] Ontario Auto Insurance Anti-Fraud Task Force Final Report, p. 19
[32] FSCO Three Year Review, December 2014, p. 40, http://www.fsco.gov.on.ca/en/auto/3yr-review/Documents/aoda-3yr-review.pdf
[33] Review of the Mandates of the Financial Services Commission of Ontario, Financial Services Tribunal, and the Deposit Insurance Corporation of Ontario, p. 80
[34] It is unclear how these cases settled, or whether they were settled. Data not available.
[35] The cases that FSCO has no information on how they finally settle, as information is not provided to FSCO, are: 115,908 – 45,608 (Full Settlements) – 44,599 (Proceed to Arbitration) = 25,701.
[36] An OCF 18 is used to make the following claims:

- Ambulance or other goods or services provided on an emergency basis
- Drugs prescribed by a regulated health professional
- Goods with a cost of $250 or less per item
- Dental goods or services