# FOLA's RESPONSE TO:

# "FAIR BENEFITS FAIRLY DELIVERED: *A Review of the Auto Insurance System in Ontario*"

Submitted to:

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## Introduction:

Thank you for the opportunity to provide written submissions on this very important issue impacting the drivers of motor vehicles and the victims of accidents across Ontario.

The Federation of Ontario Law Associations (FOLA) is an organization that represents the associations and members of the 46 local law associations found across Ontario. Together with our associate member, the Toronto Lawyers' Association, we represent approximately 12,000 lawyers, most in private practice in firms across the province as they provide service to the public and operate their businesses. These lawyers are on the front-lines of the justice system and see its triumphs and shortcomings every day.

We are an advocate for a better justice system that recognizes the crucial role competent and professional lawyers play in that system. A relatively small percentage of our members work in the field of personal injury or insurance law, but all of our members are unified in our belief that access to the courts and a justice system is a fundamental right of every citizen. We stand against any move that diminishes this right to access fair justice and competent representation and advocate for positive reforms to legislation, regulation and systems that will improve this access.

Typically, an organization of our breadth and size, with members in diverse practices throughout Ontario, cannot hope to provide a consensus position on an issue as complex as this, but on this issue, we have heard from many members who are concerned with the direction that this report and the policies enacted by your government have so far taken. What is clear from discussions that we have had at our own meetings, is that there is a great deal of misunderstanding and misconception around the issues by both policy makers and the general public. We urge a fact-based evaluation of the policy options and encourage the Ontario government to continue dialogue with those who are in the system, such as lawyers like those represented by FOLA. Of course, the viewpoints of the citizens of Ontario – our clients and potential clients, the people we serve – need to be understood and respected in this process, but those views need to be informed by fact.

In our submission, we attempt to strip away some of the hyperbole surrounding this complex issue and examine the facts. Our first challenge is to the claim that average insurance claims <u>costs</u> are actually increasing (or at least challenging the assumptions to why they might be going up).



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## ARE INSURANCE CLAIMS COSTS TRULY INCREASING?

In his Fair Benefits Fairly Delivered Report ("the report"), Mr. Marshall states:

> *"I was asked to provide advice to the Minister of Finance on the development of further initiatives to reduce claims costs and uncertainty in Ontario's auto insurance system."*[1]

A fundamental premise within the report is that insurance claims costs have been on the rise and, as a result, average insurance premiums have increased. FOLA is having great difficulty finding evidence that insurance claims costs are on the rise. We would submit that any suggestion of increasing claims costs should be thoroughly investigated by the provincial regulator. From our perspective, in light of the regulatory changes that have been put in place in the Ontario auto insurance system over the past six years, particularly when coupled with the Ministry of Transportation's data on motor vehicle accident injuries, insurance claims costs should be decreasing, not increasing.

Chart 1 in the report[2] shows the comparison between average auto insurance premiums and average claims costs per vehicle from 1990 to 2015. What is apparent is that subsequent to the 2010 insurance reforms, claims costs dropped considerably. Since 2012, claims costs crept up but are still nowhere near levels seen in 2009 and 2010. What is equally clear from Chart 1 is that, despite the fact that average claims costs went down after 2010, average insurance premiums stayed high. In fact, it would appear that between 2011 and 2015, average insurance premiums per vehicle ranged anywhere between 35% to 85% higher than average claims costs per vehicle.

Chart 2 in the report[3] relates claims costs to total injuries and severity of injury. Despite the fact that total injuries and the severity of injuries have gone down, and have been going down for more than a decade, total claims costs have been on the rise, particularly since 2012.

At the time the report was published, the 2014 Ontario Road Safety Annual Report[4] had yet to be released. That report is now out, being the most comprehensive data available relative to road traffic accidents and injuries. The Annual Report demonstrates that the number of fatalities and injuries on the Province's roadways has steadily declined over the past decade. In 2014, the number of injuries on Ontario roads was 25% less than the prior decade. That put the number of injuries on the Province's roadways at its lowest level since 1964.[5]

Relative to the severity of injury in car accidents, the Annual Report notes that of all injuries or fatalities sustained in traffic accidents, only 2.3% (a total of 2,282 people for the entire Province, including those drivers who were at fault for the accident) were admitted to the hospital; 45.6% (45,778 people) had no injury; 27.85% (27,937 people) had minimal injury (did not go to a hospital

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[1] At page 5
[2] At page 18

[3] At page 19
[4] http://www.ontario.ca/orsar
[5] At pages 9 and 15 respectively



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at all) and 23.8% (23,862 people) had a minor injury (were treated in an emergency room but not admitted)[6].

What these statistics tell us is that the vast majority of people involved in traffic accidents have no or very modest injuries. To the extent that those people who have minimal or moderate injuries seek compensation for those injuries, their claims are going to be met with two hurdles from the *Insurance Act*. First, in order to be entitled to any compensation for pain and suffering, the injured party must meet a statutory threshold of permanent and serious impairment of function[7]. Second, any claim for general damages for pain and suffering is reduced by a statutory deductible, which currently stands at $37,385.17[8].

Recent amendments to the *Insurance Act*, both relative to tort and accident benefit claims, have further reduced entitlements to recovery and compensation. Those amendments include:

- Reductions in the prejudgment interest rate on general damages for non-pecuniary awards – effective January 1st, 2015.

- Reduction in the interest rates on disputes under the Statutory Accident Benefit Schedule – effective January 1st, 2015.

- Indexing the deductible on general damages for non-pecuniary awards such that the deductible for pain and suffering damages is now $37,385.17 and the deductible on Family Law Act damages is now $18,692.59 – effective August 1st, 2015.

- Increasing the monetary threshold at which no deductibles apply such that the threshold for general damages for pain and suffering is now $124,616.21 and the threshold for Family Law Act damages is now $62,307.59 – effective August 1st, 2015.

- Tightening the definition for catastrophic impairment – effective June 1st, 2016.

- Reduction in the benefit levels under the Statutory Accident Benefit Schedule, including halving the amount for attendant care and medical/rehabilitation benefits in catastrophic injuries and reducing those same benefits for non-catastrophic injuries – effective June 1st, 2016.

In combination between fewer total injuries and fewer major injuries and the *Insurance Act* amendments, which further reduced claims in both tort and accident benefits, every expectation would be that, certainly since 2015, claims costs should be going down. Yet, the report states:

> *"Further changes in benefits were implemented in 2015 to curb costs, but trends indicate that costs will once again rise despite these changes."*[9]

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[6] At pages 25 and 26
[7] *Insurance Act*, R.S.O. 1990, s. 267.1(2)
[8] *Insurance Act*, as amended by Bill 91
[9] At page 19



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This statement is noteworthy. In fact, this statement screams for an explanation and supportive evidence. There is a total disconnect between the assertion that claims costs are going up when the clear expectation should be that claims costs, and therefore insurance premiums, should be going down.

We are aware of no evidence that, on the tort side of claims, jury verdicts are any higher now than they were five years ago. There is certainly no evidence in the report to suggest such a trend. We are aware of no evidence that out of court settlements, whether on tort claims or accident benefits claims, are higher now than they were five years ago. There is certainly no evidence in the report to suggest that trend. We are therefore left to wonder how claims costs could possibly be going up.

One possible reason for a potential rise in the tort side of claims is the fact that Statutory Accident Benefits have been reduced significantly over the past two reform initiatives. When the Government of Ontario decides to cut medical/rehabilitation benefits in half from $100,000 to $50,000, to eliminate housekeeping claims for non-catastrophic injuries and continues income replacement benefits at $400 per week (the same level it has been at since 1996), it should have been expected that tort claims would have to offset those reductions. That stated, a potential increase in tort claims costs should be offset by a corresponding reduction in claims costs on the accident benefit side of claims, due to the aforementioned cut backs. Overall costs should therefore not be expected to rise.

We understand that the premise behind the report was to address the trend of rising claims costs and, by extension, rising insurance premiums. However, this premise is not well founded and is certainly not explained within the report. The entire premise behind the report is faulty and demands further investigation by the provincial regulator.

It is noteworthy that a similar attempt to address rising costs and the need for lower premiums was attempted in 2003. At that time, significant reforms were instituted and the Ministry of Finance made the following promise:

> *If these reduced costs are not passed on to consumers, the Government will take action, including measures directly targeting auto insurance premiums, to ensure that auto insurance remains affordable and available for Ontarians. These measures could include rate caps, rate freezes or rate roll-backs."*[10]

We are not aware of any steps taken to ensure this has occurred. Any further reforms must ensure that the reductions within the system are not borne by the injured and vulnerable to the benefit of the insurers' profits.

The above referenced reforms to the *Insurance Act* are recent (2015 and 2016). The impact of those reforms needs to be fully explored before the regulator should consider effectively reinventing the wheel relative to vehicle insurance. In FOLA's submission, if the insurance industry is going to continue to claim that the claims costs are rising, it is incumbent on the

[10] "White Paper: Automobile Insurance Affordability Plan for Ontario: Next Steps", Ministry of Finance, July 2003



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regulator to conduct a deep dive into the industry's data to verify the reliability of any claims for rising costs. To that end, FOLA contends that efforts to make significant changes to Ontario's auto insurance system for the purposes of reducing claims costs and insurance premiums is premature. Instead, the regulator should monitor the impact of the 2015 and 2016 reforms and should have a reasonable expectation that in combination with fewer traffic accidents and fewer serious injuries, insurance claims costs and premiums should decline.

## IMPLEMENTING THE REPORT'S RECOMMENDATIONS WILL INCREASE COSTS

If Mr. Marshall was tasked to develop initiatives to reduce claims costs, many of his recommendations will not only fail in that regard but will actually increase claims costs. We would offer up the following as some examples:

### Independent Examination Centres (IEC's)

FOLA is strongly opposed to the concept of IEC's for reasons that will be discussed more fully below. However, simply on a cost perspective, IEC's will increase costs.

A number of the recommendations within the report incorporate the recommendation for Independent Examination Centres (example: recommendations 4, 8, 9, 17 and 24). The recommendation for IEC's is clearly a major thrust in the report. However, what is missing is any attempt to cost out the establishment and operation of various IEC's across the province. What is being contemplated obviously comes with a significant cost. That cost is going to be passed down to the policy holder. This is contrary to Mr. Marshall's mandate. He was tasked to develop initiatives to reduce claims costs, not increase them.

While reference is made within the report to the ill-fated Designated Assessment Centres, the Independent Examination Centres' concept is eerily similar. The Designated Assessment Centres were discontinued as they were found to add considerable cost into the system, with little benefit. An attempt to distinguish the IEC from the former DAC process is based on the timing of the involvement of IEC. The report recommends that the IEC become part of the plan of care of the individual and not merely form part of a dispute resolution process.

While an impartial IEC that is separate and distinct from both the insurer's medical professionals and the treating professionals of the insured may hold some benefits, there are still problems to be considered. For example, it is unclear how such a system would work in a small Ontario community, where there may be few medical specialists available, if any, who could act as an IEC assessor. One could foresee a Toronto or large centre-based IEC where Ontarians from throughout the Province would be beholden to the view of a few professionals. This would result in significant travel costs to the insured. Who would pay those costs?

The IEC would apparently be tasked with assessing the insured and providing an opinion on care that may conflict with the insured's own medical professionals. It would therefore be a key component of the IEC to ensure that those medical professionals involved have higher training than the average practitioner throughout Ontario and are continually updated on new treatment options that may be available. Otherwise, how could an insured person in Ontario feel



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comfortable that this new process and recommendations that may overrule those of his or her own treating professional?

More practically, the professionals within the IEC would, presumably, have very limited access to the injured insured. There would be very limited, if any, ability to follow up with the insured to determine the outcome of whatever treatment or recommendation the IEC professional had made. In the "real world" of medicine, the physician will assess the patient, perhaps order diagnostic testing, and then undertake a number of follow up appointments to measure the efficacy of the treatment provided. In an IEC system, there will be one assessment with no follow up. That is a far inferior method of providing medical care to an injured person and presumes that accurate diagnoses and prescription for treatment will happen after just one visit, in every case. What happens if an accurate diagnoses and prescription doesn't take place?

Timing is another concern. It is difficult to conceive of an IEC system where delays in assessment are not common. If the IEC professional's opinion is going, to a large extent, determine the treatment, the assessment would have to occur in a very timely manner, as all stakeholders should agree that delay in treatment would be at the complete detriment to the insured, and – in many cases – result in higher treatment cost.

If the provision of care is truly the goal of this report, why would benefits not be based on the treatment recommendations of the insured's treating physician(s)? Why would an IEC be able to overrule the clinical judgment of the treating practitioner, who has treated the injured patient and has first-hand knowledge of any barriers to recovery? The failure to follow the advice of the treating health professional would presume that he/she is making inappropriate recommendations. We do not expect the Province to form a system similar to an employment benefit carrier, where all that is required is a referral. We appreciate that there are other matters involved including causation. However, if the true goal is care, that is the type of system that is required. Absent that type of system, there needs to be a manner in which the insured can dispute a decision that does not accord with the opinion and advice of his or her own treating professionals.

### Allow an Examination Under Oath of Expert Witnesses (Recommendation 22)

Examinations under oath of expert witnesses, known as depositions in the United States, would lead to significant increase in claims costs. Experts are part of the automobile insurance compensatory system. In fact, to advance a claim in tort, an injured plaintiff is mandated by statute to adduce evidence from one or more physicians that explains the nature of the impairment, the permanence of the impairment, the specific bodily function that is impaired and the importance of the specific function to the person.[11]

Under the *Rules of Civil Procedure*, an expert cannot testify in court without first delivering a report that sets out certain criteria, including any factual assumptions made, a description of any research conducted and the expert's opinion respecting each issue.[12]

[11] *Insurance Act*, Regulation 381/03, section 4.3
[12] *Rules of Civil Procedure*, Rule 53.03



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Mandating that a plaintiff must have expert testimony to prove his/her case and that expert must prepare a report before testifying in court is expensive enough. Allowing an examination under oath of those experts is going to add another layer of costs in an already costly proceeding.

Before any expert should give evidence under oath, he/she must fully review the file, prepare in advance with counsel and present themselves before an official examiner. The evidence is recorded and can be transcribed, at a substantial cost. This process adds considerable expense, both on behalf of the injured party and on behalf of the insurer. Once again, nowhere in the report is any attempt made to cost out the recommendation that experts may be examined under oath. This would clearly lead to an increase in claims costs.

This recommendation could also place an unexpected further barrier on experts agreeing to assist in litigation. Currently, an expert would only potentially face the stress and inconvenience of cross-examination at a hearing. Most cases resolve prior to a hearing and, therefore, there is a very small chance of the expert going through this inconvenience. Adding an ability to depose the expert as part of the process changes this dramatically without any real benefit to the result.

## Insurance Companies as Care Providers

The report recommends that insurance companies provide "appropriate medical care and income support to injured parties".[13] The report states that insurance companies should hire staff who have an appropriate level of medical and rehabilitation expertise. These frontline staff should be "case managers", as opposed to "claims adjusters". These managers should monitor the effectiveness of healthcare providers and give feedback to both the providers and the regulator on issues or conditions that can improve the care of the injured insured person. Recommendation number 35 calls for insurance companies to change the role from managing costs to delivering care to their customers.

With respect, the suggestion that insurance corporations become care providers not only adds an additional layer of expense, it is just naïve. As long as human beings operate motor vehicles, those motor vehicles will collide with each other. As a consequence of this reality, one must be insured to legally operate a motor vehicle. Insurance companies are prepared to underwrite auto insurance policies with an expectation of reasonable profit. The inevitable consequence of this structure is that insurance companies have an internal conflict of interest between the duty of good faith to the insurance policy holder and the duty to the shareholder to make profit.

Automobile insurance companies are not, never have been, and should never be, in the business of providing healthcare to its policy holders. Policy holders do not purchase insurance for healthcare. Policy holders go to their personal physician for healthcare.

Who is to provide one's healthcare is a very personal and private decision. It is a decision that should be left up to the individual. When the motor vehicle operating public shops for insurance, they do not shop for a care provider like they would a family physician. Motor vehicle insurance is purchased based on the coverage required and the rates charged. People do not, and should not, try to shop for the insurance company that provides the best medical care should they be injured in a car accident.

[13] At page 80



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Suggesting that an insurance company should hire staff with "an appropriate level of medical and rehabilitation expertise" would obviously lead to an increase in staffing overhead for the insurance industry. Are insurance companies to have staffed medical departments with physicians, occupational therapists, physiotherapists, psychologists, etc. in order to underwrite insurance policies? Are those healthcare professionals then to adjust files?

As with other recommendations in the report, the costs consequences of this recommendation are not provided. Once again, if the mandate of the report was to develop initiatives to reduce claims costs, recommending that insurance companies hire healthcare professionals as claims adjusters is going to do nothing but increase costs.

## THE WSIB EXPERIENCE AND THE VOICE OF THE INJURED MOTORIST

Throughout the report, reference is made to the WSIB system, which is very understandable given Mr. Marshall's background with the WSIB. The report seems to hold up the WSIB system as being superior to the auto insurance system, particularly with respect to cost. What is missing in the report is the fact that the WSIB system is universally condemned by labour groups, injured worker groups and medical care providers.

In the January 29th, 2016 edition of The Toronto Star, it was reported that a 200 page submission was made to the Ontario Ombudsman by healthcare professionals, workers, lawyers and labour groups criticizing the WSIB for ignoring the medical advice provided by doctors who were treating their injured worker patients. The advice of the treating medical doctors was being rejected in favour of "paper doctors" on behalf of the WSIB, who had not even met or examined the injured worker patient.

In a June 10th, 2016 edition of The Toronto Star, it was reported that healthcare services for injured workers under the WSIB system were cut by as much a 40% for rehabilitative treatment and 30% in drug benefit spending. It was again reported that the medical advice of the injured worker's treating doctors was routinely rejected in place of opinions provided by physicians within WSIB clinics.

The internet is replete with examples of injured workers being sent back to work contrary to the opinions of their treating medical specialists. The WSIB is routinely criticized for following the directive of physicians within its own assessment centres and ignoring the opinion of treating physicians.

It is beyond the scope of this submission to go into a detailed critique of what is wrong with the WSIB system and why that system should not be incorporated into the auto insurance system in Ontario. However, the shortcomings of the WSIB system and the concerns that are consistently raised by labour groups, injured workers' groups and physicians does raise an important issue relative to the people who are injured in car accidents.

As earlier referenced, the data from the 2014 Ontario Road Safety Annual Report is encouraging as it relates to road traffic injuries and fatalities. In 2014, it was reported that Ontario's fatality rate of 0.53 per 10,000 licensed drivers was the lowest ever recorded in Ontario. The actual



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number of traffic fatalities on Ontario roads in 2014 was 517, which was the second lowest number of fatalities since 1944.[14]

The Annual Report notes that of a total of 54,081 injuries, 2,282 were serious enough for the individual to be admitted to hospital.

While the numbers are encouraging, since they are going down, the fact remains that every year in Ontario hundreds of people die in vehicular accidents and many more are seriously injured. The sad reality is that every year, families face deep loss and tragedy. Hundreds of people suffer life altering injuries such as spinal cord, brain damage and devastating orthopaedic injuries.

FOLA has a concern that in this process of insurance review, the voices of the families who have lost loved ones and the voices of the people who are seriously injured, are not being recognized. The question then becomes, who is to be the voice of those who are the victims in traffic accidents? Obviously, the insurance industry is not that voice. Does the regulator consider associations populated by lawyers such as FOLA, the Ontario Trial Lawyers Association, The Advocates Society or the Ontario Bar Association to be the voice of the fatally and seriously injured? Or does the regulator believe that lawyer based associations are touched by self-interest and therefore cannot be objective when it comes to insurance reform? Are the treatment providers such as psychologists, occupational therapists, physiotherapists, etc. to speak for accident victims? Or does the regulator see such groups as also being tainted by self-interest since part of their revenues come from the car insurance first party system?

In a compassionate and liberal democracy such as Ontario, some pause should be given to consider who best speaks on behalf of those who are killed or injured in vehicular accidents. Although the data is encouraging and both the fatality and injury rates are falling, the fact remains that every year, people will die in traffic accidents and other people will be seriously injured. That is a certainty and it will happen this year, next year and for many years to come. Some group or association has to speak for these victims of accidents, just as labour groups and unions speak out for injured workers. In FOLA's submission, during the process of considering Mr. Marshall's recommendations, the regulator must give consideration to the voices of the families of the deceased and those who are injured. Insurance reform must mean more than simply charts, graphs and financial statements. It is incumbent on the regulator, when reviewing the various submissions received on Mr. Marshall's report, to ensure that the voice of the victims, past, current and future, is being recognized before any final decisions are made on further insurance reform. If the regulator is not satisfied that the voice of the injured is being heard, it may be time for the regulator to consider providing reasonable grant funding to some group or association that it has confidence will provide a reasonable, objective and balanced perspective of those who are injured every year on Ontario's roadways.

[14] 2014 Ontario Roads Safety Annual Report at page 7



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## THE LAW SOCIETY OF UPPER CANADA AS THE REGULATOR OF THE LEGAL PROFESSION

The legal profession in Ontario is regulated by the Law Society of Upper Canada ("the Law Society") through the *Law Society Act*. Lawyers in the Province of Ontario must follow the *Rules of Professional Conduct* as amended from time to time by the Law Society.

The report makes a number of recommendations that tread into the jurisdiction of the Law Society and are in conflict with recent amendments to the Rules of Professional Conduct. Specifically, in reference to recommendation no. 12:

***a) Banning or Restricting Advertising and Referral Fees and Restricting Contingency Fees in Personal Injury Cases***

Commercial advertising is protected as freedom of expression under section 2(b) of the Charter of Rights and Freedoms. This was clearly stated 17 years ago by the Supreme Court of Canada.[15] The regulator cannot outright ban advertising.

Relative to restricting advertising, referral fees and contingency fees, in fairness to Mr. Marshall, since he authored his report, the Law Society amended the *Rules of Professional Conduct* to restrict lawyer advertising and referral fees. No further restrictions are required at this time.

Relative to contingency fees, the Law Society's Advertising and Fee Arrangements Issues Working Group released a report to Convocation in June 2017 and has put out a Call for Input, which is due back on September 29th, 2017. Therefore, the Law Society is already looking into restricting contingency fees. No further action is required.

***b) Requiring Contingency Fee Arrangements to be Filed with the Regulator***

This is a Law Society matter and the aforementioned Working Group is looking into requirements relative to contingency fees. This need not be visited further.

***c) Settlement Cheques Should be Made Payable Jointly to the Accident Victim and the Lawyer***

This is not required since the Law Society already mandates that settlement funds must be completely accounted for so that the client is fully informed as to the amount of the settlement and the amount that the client ultimately receives.

FOLA knows of no example where a client was not aware of the totality of the settlement. We further are unaware of any example of lawyer fraud committed against the personal injury client in failing to report the totality of the settlement funds and the fees being charged.

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[15] *Rocket v. Royal College of Dental Surgeons of Ontario* [1990], S.C.J. No. 65



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***d) Claimants Should be Informed in Writing of Their Right to Appeal the Fees Charged by the Lawyer***

Regulation 194/04 of the *Solicitor's Act* requires that a contingency fee agreement inform the client of the right to ask a judge of the Superior Court of Justice to review and approve the solicitor's bill.[16] The aforementioned Law Society Working Group is already considering further and enhanced client reporting, including additional reminders to the client of the right to have the final account assessed by a Superior Court judge. Therefore, this is a matter that is already being addressed by the Law Society.

One thing that FOLA would like to remind the regulator is that an assessment of a solicitor and client account relative to a contingency fee must go before a judge of the Superior Court. Assessment officers have no jurisdiction over the enforceability of a contingency fee agreement, including as to whether the agreement is both fair and reasonable.[17] The regulator might want to consider the effect on the workload on the Superior Court bench should there be a sudden increase in solicitor and client assessments. The civil court lists across this province are already under severe stress. Those lists do not need further stress.

Recommendations 26, 27 and 28 seem to be a duplication with Recommendation 12. Once again, the Law Society is the appropriate regulator and it is currently taking steps to address some of the concerns surrounding contingency fee agreements. The Provincial regulator need not get involved when it is the Law Society that is tasked with regulating the legal profession in Ontario.

## ACCESS TO JUSTICE FOR THE INJURED

As noted above, FOLA is concerned with the premature nature of this review in light of the recent implementation of changes to the SABS and the dispute process through the LAT in 2015. The report's expression of concern over legal representation for the insured in recommendations 11, 12 and 13 is difficult to reconcile given extensive reforms that have occurred over the past few years in a very complicated regime.

A recommendation that there be no cash settlements for medical/rehabilitation benefits would, in effect, reduce an ability for lawyers to assist an insured who needs to dispute denials of treatment plans through the LAT process. As the regulator will be aware, the LAT does not award costs and therefore lawyers for the insured would only be paid for their representation if an insured has the ability to fund the lawyer fees personally (which is a rarity) or if there is a potential cash settlement at the end of the file for which contingency fees could be charged. A dispute over one or two treatment plans for less than $10,000 would not support a lawyer conducting an LAT proceeding. This is a fact that is also known to the insurer.

[16] At section 2.8

[17] *Evans Sweeny Bordin LLP* v. Zawadzki et al, 127 O.R. (3d), 510, CA, at para. 16 & 17



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If the insurer is aware that the insured will not have the financial resources to challenge a denied treatment plan, what would stop an insurer from routinely denying treatment plans and letting the insured take the financial risk of taking the matter to the LAT? In a system where the insured is already at a monetary disadvantage during a dispute, the recommendation that there be "care not cash" may have very significant ramifications for the insured. Specifically, those ramifications amount to a denial of access to justice.

Found within these recommendations is an implicit concern that lawyers are profiting from their work within the SABs to the detriment of the injured person. If this is the concern, further consultation with lawyers who actually practice in this area is required. Most lawyers who represent individuals on the SABs have been retained for the tort litigation and are trying to assist their client as an added service. Non-CAT clients have a $65,000 limit in combined medical/rehabilitation and attendant care benefits. There must be statistics, held by the insurers, as to the average lump sum settlement paid for non-catastrophic medical/rehabilitation benefits. FOLA would be surprised if lump sum payments for medical/rehabilitation benefits would be in excess of $20,000. A 20% contingency equates to $4,000 in legal fees. That is far preferable to an hourly rate retainer, where the insured would be subject to much higher legal fees charged against other recoveries made for the insured.

There is no evidence that the involvement of legal representation prolongs the process or leads to a resolution where the insured is in a worse position than if a lawyer was not involved. Insurance companies have in-house lawyers who can provide legal opinions to them at any time. Is there to be a prohibition on insurers from seeking counsel on these claims as well or is it just the insured who should be at that disadvantage?

If the regulator is seriously considering a prohibition on settling medical and rehabilitation claims on a cash basis, the regulator should then be prepared to level the playing field and allow that costs be awarded in LAT hearings. Those costs should not be fixed to a scale such as the Legal Aid rate. Rather, the scale of costs awarded at the LAT should be comparable to that in Superior Court proceedings as determined under the Rules of Civil Procedure, including the jurisdiction for the arbitrator to award costs on a partial, substantial and full indemnity scale.



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## CONCLUSIONS

We hope that you will take these serious concerns and questions into consideration as you develop specific policy looking forward. We believe Mr. Marshall's conclusions, which derive from a questionable premise, will have serious and negative unintended consequences and simply force government to act again in a few short years to "fix" another set of problems. Our best advice is to shelve this report, let the 2015 and 2016 reforms and changes take root, let the Law Society examination of contingency fees and advertising take hold and continue to monitor the actual cost of claims and look more closely into who is profiting.

We remain available for further discussion and dialogue as you deliberate on these submissions.

Respectfully submitted,

Jaye Hooper, Chair
Federation of Ontario Law Associations

Mike Winward, 1st Vice Chair

cc. FOLA Executive
Presidents of Ontario's local law associations (FOLA members)
Paul Schabas, Treasurer of the Law Society of Upper Canada



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