Response to:

Ontario Automobile Anti-Fraud Task Force Steering Committee Status Update

Submitted by:

FAIR
(Fair Association of Victims for Accident Insurance Reform)

August 27, 2012

FAIR

P.O. Box 5021

Penetanguishene, ON

L9M 2G2

INTRODUCTION

FAIR (Fair Association of Victims for Accident Insurance Reform) is a grassroots not-for-profit organization of MVA (Motor Vehicle Accident) victims who have been injured in motor vehicle collisions and who have struggled with the current auto insurance system in Ontario.

Our members lives, as a result of these MVAs, have been turned upside down by brain injury, loss of limbs, need for surgery and reparative therapy, long-term debilitating injuries, loss of time from work, loss of jobs and sometimes loss of independence

FAIR wants to see reforms to auto insurance legislation that will improve the way in which all MVA victims, particularly those with traumatic injury, are treated and cared for under provincial insurance legislation. Not only are FAIR members faced with the challenges of overcoming and adapting to injury, we are also faced with an insurance system that does not fairly provide consumers with needed rehabilitation coverage and benefits. We are faced with sub-standard medical reports and are often examined by physicians acting outside of their area of expertise. Third Party Reports, prepared by physicians hired by insurers to perform IME (independent medical assessments or evaluations) are one of the core reasons for the present backlog of almost 40,000 MVA victims waiting for hearings for treatment and benefits at FSCO (Financial Services Commission of Ontario) today.

FAIR gives a voice to the thousands of people in Ontario who have become amongst the most vulnerable people in our province. We welcome the opportunity to be heard by the FSCO Anti-Fraud Task Force.

CONCERNS

There are many elements of the changes proposed by the Steering Committee that will benefit claimants and insurers. They are discussed at the end of this submission.

FAIR does not agree that lowering accident benefits will result in limiting insurance fraud. The industry has cast too wide a net that captures legitimate claimants along with those who ‘may’ be fraudulent. This has created an unfair system with decreased benefits for all. FSCO and the Task Force must deal with fraud without negatively affecting innocent MVA victims who make legitimate claims.

FAIR believes that the previous levels of benefits prior to the 2003 changes should be restored.

The most recent GISA (General Insurance Statistical Agency) report shows that between 2010 and 2011 the volume of claims is down 15% after the new 2010 regulations. The average cost per claim is almost cut in half to $28,978 - substantially less than the figures quoted by the insurance industry in the past year. The incurred claim cost per earned vehicle is $292.60 in 2011, well below the $595.75 in 2010, before the reduced benefits came into effect. This has created a boom year for insurers in 2011 and profits for some insurers have doubled while 40,000 claimants line up in the queue at FSCO. Legitimately injured claimants that may wait up to two years to have their denied claims reviewed before receiving treatment or income replacement benefits.

As pointed out in the KPMG report, the opportunistic fraud associated with claimants cannot be accurately verified. The war on fraud and focusing on benefits claimants are entitled to captures

legitimate claimants all too easily. The IBC assigned a 1.3 billion dollar a year loss figure to fraud for almost 20 years as ‘fact’ and the insurers simply added this long-unsubstantiated loss estimate into consumer’s premiums. When finally questioned about this huge loss of approximately 26 billion dollars over 2 decades, the industry admitted that it doesn't know where the figure came from. By then consumers had seen premiums go up and benefits slashed. The lesson here is that statistical "research" advanced by the IBC should be viewed with caution and stakeholders should agree on what the ‘facts’ are before making changes to accident benefits.

FAIR believes that the FSCO Anti-Fraud Task Force has initiated a wholly one-sided investigation into fraud. Insurers must also be under the microscope and their actions examined with the same dedication applied to other stakeholders. It is here, in this Task Force forum, that all stakeholders meet and where treatment of all the parties must be fair and equitable. It is glaringly obvious that insurer doctors are not on the Anti-Fraud Task Force’s radar for their fraudulent acts when producing substandard or biased reports. While this Task Force discusses laying criminal charges against claimants, rehabilitation workers and tow truck operators, insurer assessment physicians are exempted from any examination of their actions and are excluded from the Task Force research mandate. The 40,000 injured Ontarians currently waiting for FSCO compulsory mediation regarding denied benefits and treatment hearings would not agree that those "preferred" IME/IE vendors, who act in the best interest of insurers and whose reports endlessly accuse legitimate claimants as fraudsters or malingerers, should be given a free pass by the Task Force.

To fully examine fraud one must look critically at what is happening to tens of thousands of vulnerable and injured claimants who are routinely labelled as fraudsters. The Task Force needs to question how over half of all claimants are being denied benefits. The Task force needs to scrutinize insurer tactics by way of biased, substandard and unqualified ‘expert’ reports. The Consumer Bill of Rights posted on the FSCO website states that claimants should have the right to fair claims handling. FAIR is questioning the ‘fairness’ of biased and unqualified insurer assessments.

Ignoring the fact that tainted or false assessments are a regular part of Ontario auto insurance industry claims handling practices will only lead to greater numbers of claimants lining up for hearings at FSCO. The CSME (Canadian Society of Medical Evaluators), an organization whose members routinely perform IMEs on many thousands of Ontario’s injured auto accident victims had the following to say: CSME President (Dec. 2011) Message to Members: ***"...We have all to realize that times are changing - amateurism, bias and fraud in the domain of IMEs will be tolerated less and less in the future. For those of you doing IMEs for years, it is time to notice this approaching shift: the cost of litigation, cost of automobile insurance and lack of quality control of IMES, leading to public scandals, might soon lead the parties requesting IMES to be more critical when the appraising medicolegal credentials of an expert before hiring his/her services...."***

The Fraud Task Force must look at this acknowledgement of poor quality, biased and fraudulent IMEs by the assessors themselves and explain why these physicians are not being scrutinized. Why the free pass? Looking the other way isn't good enough and in fact displays a biased approach by the Task Force itself.

Consumers cannot look to CPSO’s Third Party Report policy position as a means to police these insurer "hired guns"/physicians. A stated mandate that: ***“Physicians must be honest, objective and impartial. They must ensure that the opinions they provide are reasonable, fair, balanced, and substantiated by fact.”*** does not guarantee compliance. Unfortunately there has been a long history at CPSO of ignoring

those IME physicians who prepare substandard and biased reports as well as physicians who opine outside their area of expertise or engage in 'practice drift'. CPSO's failure to report patient complaints about IME physicians to the public has created an unsafe environment for Ontario's most vulnerable injured MVA victims. This lack of transparency enables a group of pro-insurer physicians to carry on their business with impunity and calls into question whether CPSO's self-regulation is effective.

Greater accountability and disclosure of the costs that the insurance industry attributes to fraud should be examined by this Committee. Insurers must disclose the breakdown of the numbers and what is included in their estimation of the cost of fraud. The cost of fighting legitimate claims is often more than the claim itself. Industry practices that lead to higher costs when the insurer classifies legitimate claimants as fraudsters should be examined; over-assessing claimants, staged assessments, unqualified or biased assessments, substandard reports, 'stacking' of reports, blocking legitimate claims and denying timely treatment contribute to higher costs.

Insurers are paying more to deny cases than they would have to pay out by just paying benefits they legitimately owe. Ontario's court system has recognised this in the case of ***McQueen v. Echelon General Insurance Company, (2011 ONCA 649).*** The court found that the plaintiff had suffered mental stress after her insurer had made 21 denials for treatment in just over 3 years. The claimant was awarded $25,000 for aggravated damages.

This insurer paid out $175,000 to deny $20,000 in treatment costs and the court found that it contributed to the claimant's mental distress when the insurer engaged in bad faith conduct. Rubber-stamped denials are more than just a deceptive business practice; they are part of an established system of denying legitimate claims by way of fraudulent acts carried out by doctors in fee for service relationships with insurers.

In *Fidler v. Sun Life Assurance Co. Ltd.*, 2006 SCC 30 (CanLII), 2006 SCC 30, [2006] the Supreme Court found that an insurer owes a common law duty to act in good faith in all its dealings with an insured:

"The bargain was that in return for the payment of premiums, the insurer would pay the plaintiff benefits in the case of disability. This is not a mere commercial contract. It is rather a contract for benefits that are both tangible, such as payments, and intangible, such as knowledge of income security in the event of disability. If disability occurs and the insurer does not pay when it ought to have done so in accordance with the terms of the policy, the insurer has breached this reasonable expectation of security.

Mental distress is an effect which parties to a disability insurance contract may reasonably contemplate may flow from a failure to pay the required benefits. The intangible benefit provided by such a contract is the prospect of continued financial security when a person's disability makes working, and therefore receiving an income, no longer possible. If benefits are unfairly denied, it may not be possible to meet ordinary living expenses. This financial pressure, on top of the loss of work and the existence of a disability, is likely to heighten an insured's anxiety and stress. Moreover, once disabled, an insured faces the difficulty of finding an economic substitute for the loss of income caused by the denial of benefits."

FAIR believes that providing insurers with broader civil immunity will create an unfair advantage to the insurer and likely lead to even worse abuse of accident victims. If one reviews the McQueen v. Echelon

decision in the light of the Fidler v. Sunlife decision (above) it is easy to see why the insurance industry wants broader civil immunity. A more likely motive is that the insurers find themselves exposed financially when claimant abuse gets out of control and this is resulting in court awards. The introduction of such a change will boldly state that Ontarians are not all equal under the law, once injured in an MVA, your rights are diminished.

The establishment of a dedicated fraud investigation unit has been attempted in the past with the IBC (Insurance Bureau of Canada) and the ICPB (Insurance Crime Prevention Bureau). Such a program led to widespread abuse and intimidation of legitimate claimants and was extensively covered by the media. FAIR believes that this is invasive and abusive and will create even greater discord between the policy-holder and the insurer. The coupling of a greater ability to share claimant's personal information with broader civil immunity in the realm of a revamped quasi-police investigatory body without oversight and beyond the reach of the law would create intolerable circumstances for claimants. Claimants who could be abused by their insurer with absolute impunity.

The proposed changes to consent and disclosure of the personal information of claimants by imbedding consent in applications for benefits and a system of sharing that information with unspecified individuals or companies is an infringement of a person's right to privacy. Consent should be obtained separately from the benefit application as these are two separate acts despite one being dependent on the other. Claimants can be approached on a per use basis, by consent form. Under past regulation insurers would disclose whom they were going to share the information with and consent was for a limited time and limited use. Consumers have a right to be concerned about how any large corporation handles their personal information for security reasons.

The proposed penalty of $500.00 for failure to attend an insurer examination appears to be a double-dip penalty as claimants are already responsible to pay for a doctor's examination if they fail to properly cancel an appointment. Appointments are cancelled for a variety of reasons including cancellations by legal representatives when they become aware of previous assessor bias. One could ask where does a seriously injured claimant, waiting in line at FSCO for mediation for denied income replacement benefits get $500?

The requirement that CEO's of auto insurance companies are to attest that legitimate claimants are treated fairly will be largely ineffective. CEO's cannot reasonably be expected to be aware of the actions of their employees who deal with claims on the ground.

FAIR supports those changes that promote more transparency in the system and greater regulation for rehabilitation clinics and service providers. FAIR agrees that claimants should sign for goods or services that they receive and the feedback on HCAI is that claimants are now better aware of those goods and services.

The proposal that claimants be examined under oath introduces an additional burden to the claimant as well as costs to the insurer and appears to offer little value. Claimants are already challenged with recovery and should not be expected to track purchases by their therapists. HCAI does keep the claimant in the loop of expenses applied for and approved but claimants should not be asked to verify whether one brand or another at one cost or another is correct. There is no issue with an insurer asking whether services or equipment has been received, in fact they should do so, but to do it under oath is unnecessary.

FAIR members agree that the public remains unaware of the amount of coverage their automobile

insurance company offers. Most consumers do not know the limits of their coverage and have not purchased those extras that include enhanced income replacement or attendant care coverage. In large part this is because the insurers have told the public that the basic package is all they will ever need. This is conveyed in the word ‘basic’ which leaves consumers to believe that they have ‘enough’ coverage.

Most policy holders have no concept of the costs of rehabilitation and are not able to link the cost of recovery to the severity of injuries. $50,000 sounds like a lot of money, so how seriously does one have to be hurt to need more than this? More information must be given to consumers; statistics about the costs of recovery set beside the cost of enhanced coverage may be one way to bring awareness. This could be included with consumer’s renewal policies. The IBC’s use of cartoon frog characters to portray injured Ontarians in their recent PR campaign does not assist consumers with taking auto accident injuries seriously and is demeaning to those who struggle every day to overcome injuries.

FAIR supports the creation of a new regulatory body to oversee healthcare and assessment facilities as proposed by Mr. Willie Handler. FAIR members believe that the Ministry of Health should be part of this oversight and that public members should be included in a multi-stakeholder alliance. Front line health professionals with experience on the ground level should also be part of the proposed oversight.

FAIR appreciates the opportunity to contribute to and assist the Task Force in creating a more open and honest system for Ontario’s auto accident victims.