2013

Cheaper Car Insurance: Price is the least of the problems.

JULIE ENTWISTLE, OT, MBA

NOTE TO READER: THIS PAPER WAS COMPLETED AS AN INDEPENDENT PROJECT FOR WILFRID LAURIER'S MBA BUSINESS LAW (BU 651) COURSE IN DECEMBER 2013. IT HAS BEEN CIRCULATED WITH PERMISSION FROM WLU AND THE WRITER.

Introduction

The article “Cheaper Car Insurance: Ontario drivers will wait two more years” highlights many of the current problems in Ontario’s auto insurance industry. High premiums, fraud, problems with payouts for injuries, claim costs, resolution back-logs, and benefit cuts returning $2B back to insurers are all mentioned. As a rehabilitation provider working in the auto insurance industry, I can confirm that the current product is fraught with problems. However, from the health provider and claimant perspective, affordability is the least of the industry’s problems. Rather, there is growing concern regarding insurer practices that are unfair and deceptive, negligent, involve failed fiduciary duties, and seem to violate the Canadian Charter. Issues with professionals as assessors, and provider contracts are also rampant. This paper will review Ontario’s insurance industry, aiming to highlight the many legal problems surrounding a controversial product that impacts all drivers.

Background

Auto insurance across Canada is provincially mandated through the Insurance Act. In Ontario, coverage for all drivers became compulsory in 1979. The Financial Services Commission of Ontario (FSCO), formed in 1997, now issues and monitors the following statutes and regulations that apply to automobile insurance in Ontario: the insurance act (1990), compulsory automobile insurance act (1990), motor vehicle accident claims act (1990), auto insurance and rate stabilization act (2003) (1). Since its’ creation in 1990, the insurance act, now termed the Statutory Accident Benefits Schedule (SABS), has had six main revisions (1990, 1994, 1996, 2003, 2006, and 2010), each aimed at controlling rising insurance rates (2). In fact, Ontario has the highest average premiums in the country at 30% higher than the next closest province, with a 10 year premium growth of 65.85%, highlighting the problems with affordability (2).

There are many stakeholders in the industry. From the driver that becomes a consumer of insurance benefits at the time of claim, to the body shop, tow truck driver, rehabilitation professionals, federal and

provincial governments, public health insurance (OHIP), and FSCO: all with a vested interest in this complicated product. The Insurance Bureau of Canada (IBC), formed in 1964, is another key industry player. They represent Canada's home, car and business insurers and assume the role of forecasting and responding to issues in the industry, identifying opportunities to assist members, and lobbying the federal and provincial governments to benefit insurance companies and their customers (3).

Currently, there are over 90 licensed insurance companies in Ontario with 20 holding 75% of this market (4). In 2009 the 7.5M insured vehicles in Ontario amounted $9.8B in premiums. The cost to handle injuries accounted for $4.5B, with 62K Ontario residents injured in 2009. Of these injuries, 60% were "minor", 39% (24,170) "severe", and the remaining 1% (620) "catastrophic" (4). In 2010, the average injury claim cost was $56K, while the average total claim cost per insured vehicle was $764.21 or $5.73B. Recent (2010) legislative changes have resulted in significant claim cost reduction, and in 2011 the average total cost per insured vehicle decreased to $300.19, reducing overall claim expenses to $2.25 billion (5). FSCO accomplished this by keeping premiums the same, but reduced benefits by as much as half. Now, "minor injuries" are capped at $3500.00 in treatment, "serious injuries" at $50,000 and "catastrophic" at $1,000,000. Benefits such as housekeeping and care giving are "optional" and less than 1% of people are "buying up" to have such coverage. Recent (2012) announcements have FSCO targeting the catastrophic designation in an attempt to reduce the number of people that qualify by half. With the substantial difference in monetary benefits between catastrophic and not ($50,000 to $1M), this change will have significant impact on the most severely injured, in an already troubled system.

Insurance contracts are unique in that "the courts will not enforce a contract of insurance when the claim arises out of a criminal or deliberate wrongful act of the insured" as "it would be contrary to the purpose of insurance to allow the insured to recover compensation for a loss that he deliberately caused" (6 p. 374). However, it is believed that the nature of the insurance product creates incentives to report fictitious or exaggerated losses, since receiving insurance payments can lead to financial gain for the

claimant. This negative consequence is intrinsic to all insurance systems, and the design of the insurance contract, insurance contract law, claims handling practices and even the selection of insurance customers must take this into account (2). Protecting from claim's abuse is an important facet of insurance in both public and private systems, and involves both criminal and civil procedures. In Ontario, FSCO and IBC report fraud to be a significant problem, costing the system $1.5B annually (4).

Importantly, "an insurance policy is a document that provides written evidence of the terms of an insurance contract" (6 p. 369). This contract includes the nature, amount and duration of coverage and the premium for the same. In Ontario, mandatory auto coverage includes accident benefits, liability, uninsured automobile, and property (vehicle and contents), with optional increased liability, loss or damage, and "other" (7). While the basic coverage is the same for all motorists, the "other" and "optional benefits" makes for some flexibility in the contracts across the insured. However, it is unclear how many insurers actually explain the contract to consumers before they sign, as many claimants indicate they didn't know what coverage they had, or that some benefits were optional. While the onus is on the consumer to understand the coverage and contract, it is well known in auto insurance that people purchase based on price and most ignore the actual product because coverage is mandatory. When the legislation changed in 2010, and optional benefits were introduced, this problem worsened as insurers and brokers were not always explaining the coverage at the time of renewal (negligent omission). Now, at the time of claim, people are finding they lack the benefits that they actually require.

It is known that insurance contracts are of the "utmost good faith" and that "this duty is owed by both insured and insurer", and that the insurer "must deal with claims fairly" and "not take advantage of its position of power over a vulnerable individual" (6 p. 379). Should the insurer be deemed negligent or fraudulent in fulfilling the terms of the contract, the claimant could be granted damages by the court (6 p. 190). It is notable that the SABS includes a subsection for "Unfair and Deceptive Practice" which serves to try and reduce inappropriate insurer conduct. This regulation (7/00) includes such clauses covering

"unreasonable delay or resistance; refusal without reasonable cause to pay a claim for goods or services; and arranging an examination by a provider who the insurer knows, or ought to know, is not reasonably qualified" (8). The independent claim's adjuster is also to adhere to the Ontario Insurance Adjusters Association Code of Ethics which states: "the adjuster shall so act as to promote public confidence in insurance companies through fair and conscientious dealing, and shall refrain from any fraud, deceit, misrepresentation, dishonest non-disclosure, undue influence or other mischievous practice" (9).

Beyond Affordability

While the issue of affordability is important for the general public and policy makers, health professionals and claimants are experiencing other significant problems with the industry. Despite the statutes, clauses and codes around fair and ethical insurer practice, there is ample and ongoing evidence in Ontario of insurers violating contracts by engaging in negligence, failing their fiduciary duty, hiring rogue assessors, and taking aggressive actions that seem to violate the Charter. Other professional issues also exist in the treatment arena, namely the use of the Ontario Claim's Form 18 (OCF 18) to secure funding.

Negligence

Negligence is defined as "anyone who carelessly causes injury to another should compensate the victim for that injury" (6 p. 66). The elements of proof in negligence cases include: the defendant owed a duty of care, they breached the required standard of care, and this caused injury or damage to the plaintiff.

It is clear in insurance contract law that the insurer owes a duty of care to a claimant. However, in the current environment, breaches are witnessed in the forms of excessive surveillance, delays in responding or resolving disputes, payment problems, and over-denying and assessing. This misconduct causes the plaintiff damage in the forms of financial crises, psychological impairment from mistreatment or bullying, and physical, cognitive and behavioral disability that results from denials and delays in treatment. These problems are not new; however, and there is previous case law regarding this. Precedent was first set in

2002 in Whiten v. Pilot Insurance when the court held that Pilot acted in bad faith during the management of the claim and awarded the Plaintiff $1M in punitive damages (6). In Fidler v. Sun Life Assurance (2006) it was determined that "it is reasonably foreseeable that intangible injuries and mental distress may flow from the insurer's wrongful refusal to pay benefits". In McQueen v. Echelon General Insurance the Plaintiff had 21 denials of 16 separate benefits over a period of three years. McQueen sued as the insurer "breached obligations…specifically its obligation to act in good faith in the handling of her claims for accident benefits". In the end, it was concluded that "Echelon violated their obligation to provide peace of mind, and there was mental suffering warranting compensation" (10). These issues continue today; however, in most cases actions brought against insurers are dropped at settlement, including any negligent or unfair practices. This is a disadvantage in the system as it prevents insurers from becoming formally accountable for their behavior, encouraging it to continue.

Fiduciary Duty

Fiduciary duty involves a special relationship of trust with a professional. This relationship has three characteristics: the fiduciary has scope to exercise some discretion of power, they can unilaterally exercise that power or discretion to affect the benefactor's legal or practical interests, and the client is particularly vulnerable, or is at the mercy of the fiduciary holding the discretion of power (6 p. 88).

There are many examples of failed insurer fiduciary duty. Often denials for benefits or services are unjustified, the assessors they hire are unqualified, benefits are withdrawn arbitrarily, opinions are not objective, and monies are not paid promptly. For example, in MG v. Economical (2013), Economical stopped making the income replacement payments saying MG had not participated in necessary and reasonable treatment (when she had). Economical held her income payments for 2 1/2 years, until just prior to the arbitration hearing, providing no explanation for the delay in reinstatement (11). In Whorpole v. Echelon, Echelon refused to pay benefits and told the family they "missed the one year period to sue"

after “losing” three sets of paperwork that were submitted on time. In another case, Justice Wendy MacPherson tossed out a low ball settlement between ING and a motorist, indicating that the adjuster “abused his position of power to enter into an unconscionable settlement” (12).

Independent Assessment and Professionals

The insurance examination process is one of the hottest topics in insurance of recent. In this, “professionals” are hired by the insurer as part of a dispute process to render “unbiased” opinions about the needs of a claimant. Beyond the perceived conflict of a professional being hired by an insurer to render an “independent” opinion, there are other issues with these assessments.

The contractual obligation between a professional and client is an agreement to provide services with a promise to perform those services competently. To breach this agreement is a breach of contract. The Standard of Care for Professionals is often well outlined. It is law for that professional to “exercise the same degree of skill and possess the same level of knowledge that is generally expected of members of that profession”. Sometimes “a professional opinion is divided” and in that case “it will normally be sufficient that the defendant has followed a well-recognized practice, even though another procedure might have been arguably better” (6 p. 99).

Many professionals are also governed by professional organizations “established under, and to some extent regulated by, provincial statutes” (6 p. 102). These governing bodies (in the medical field “Colleges”) are tasked with overseeing the practice of the profession, the use of title, entry standards, registration, and managing complaints and resolutions. The Colleges have “codes of conduct” that must be followed by the professional, and should the client be harmed or mistreated, that person can file a complaint to have the professional’s conduct reviewed, questioned, and reprimanded if appropriate.

While it would seem that a medical professional assessing for benefits or treatment is a fiduciary as they hold a position of power, and are able to exercise that power over the claimant, the courts disagree. In

Lowe v. Guarantee Company (2003) the plaintiff argued that an assessor was negligent and acted in bad faith in denying treatment. The judge indicated: "time and again, persons frustrated by the opinions and findings of professionals in litigation…have sought to claim damages on various basis, including negligence, negligent misrepresentations, fiduciary duties and others". The moving defendants "did not have a contract with the plaintiffs to create a medical duty of care, they could not be sued for breach of fiduciary duty because the assessment relationship lacked the element of expectation that the assessor would act in the interests of the plaintiff, and such a duty would be inconsistent with their neutral position. They could not be sued for what they said in their reports because such reports were absolutely protected by witness immunity." (13). In Worthman v. Assessmed (2006), the plaintiff brought action against doctor and company for which he performed examinations claiming damages bad faith, intentional interference with economic relations, inducing breach of contract, injurious falsehood, negligence and malpractice. This was dismissed and the judge opined that a doctor "retained by a third party to examine and report…owes no legal duty to the person other than to avoid injuring her", but then stated "it might be that the duty to avoid injuring the plaintiff extended to the avoidance of both psychological and economic injuries. This is an important and evolving area of law." The judge further stated that "there is a considerable body of legal precedent that, in certain circumstances, insulates medical experts from suit by third parties concerning whom they, at the instance of someone else, conduct examinations, render opinions and reports, and give evidence concerning the third parties' medical condition" (14). Apparently these suits against assessors are dismissed based on Rule 21 whereby a defendant may request dismissal if "the action is frivolous or vexatious or is otherwise an abuse of the process of the court" (15). It seems that suing an assessor (called as an expert) is seen as "abusing the process of the court", and violates the necessity in insurance to obtain those opinions.

Without the legal ability to sue a medical professional, now lawyers, clients and other health providers are taking assessor misconduct issues to the Colleges, but with limited success in accomplishing change.

Further, College decisions of misconduct short of license suspension and revocation are not public information and therefore if a professional is reprimanded or provided a warning, requires skills upgrading or additional training, this does not impact their ability to continue to assess. There are several examples of professionals whose reports are "thrown out" by the courts in a dispute, yet they are allowed to continue to practice and be reimbursed for their failed and biased opinions. In RJ v. Dominion of Canada (2013), RJ's income replacement benefits were discontinued by a series of insurance examinations. During arbitration it was determined that psychiatrist Dr. Hines essentially "missed the boat on a woman who had severely disabling depressive symptoms to the degree that she became a suicide risk". In DB v. Economical Insurance (2013), the insurer took the position that DB was not eligible for catastrophic benefits because their assessors indicated that if she had her leg amputated she would be more functional (16) (17). In Kong v. Personal Insurance (2006), Dr. Marton, a psychologist with professed expertise in chronic pain "conceded that he had not acquired the expertise and training in the assessment of the psychological aspects of chronic pain problems" (9). Other examples of "professionals" who render insurance opinions then when testifying in court are deemed to be practicing outside of their scope include Dr. Shah in brain injury (completed 997 unqualified neuropsychological assessments), and Dr. Grant who exaggerated skills in orthopedic surgery. Yet, even after having their credentials dismissed in court, these "professionals" continue to be hired as assessors even today (9). This leaves the claimant bewildered, frustrated and feeling abused as they are "forced" into assessments by sometimes unqualified professionals, significant decisions are made based on the outcome, the Colleges do nothing, and they are not able to successfully sue.

Service Provider Contract Issues

There is another "contract" that receives significant attention in the rehabilitation world. As of 1996, medical providers could not start therapy or treatment of an injured person, and expect insurer payment, without insurer approval via a treatment plan, now called the Ontario Claim's Form 18 (OCF 18) (2). In a

nutshell, anyone wanting to treat a claimant, and be reimbursed from rehabilitation monies, needs to submit this document and await approval. This OCF 18 has multiple parts including: the offeror's credentials, signature, treatment offering, rationale and cost; the claimant's information, pre and post-accident problems, and signature; the insurer's information and response. To submit an OCF 18 to an insurer, the claimant must first review and "approve" this via signature. To submit a blank form (without signature) is considered fraud. After the claimant's signature is obtained, this is submitted to the insurer for another "approval" via a mandatory online submission process. Forms submitted in any other form are not responded to. Once submitted properly, insurer has 10 days to respond with an approval, partial approval, or denial. If there is no response in 10 days, the therapist can proceed until a response is obtained. The full denial of services is to initiate an "insurance assessment" whereby the insurer obtains a second opinion on the plan. If approved, and services are provided, or completed, the therapist submits an invoice to the insurer, referencing the approved plan, and the insurer issues payment directly to the provider.

So, this begs the question, is the OCF 18 a contract between insurer and provider? The insurers argue that this is not and that their only contract is with the claimant, and as such have essentially no obligation to pay for the services once approved. This is a stunt pulled typically after settlement when the claimant has been provided the funds whilst the provider had an outstanding account, or when the insurer approved plans over the rehabilitation limits and the claimant's funds are now exhausted. In reviewing the elements of a contact, the following is noted:

Offer: Both the client and insurer are presented the OCF 18 (written document) as an "offer". The client is offered services, and the insurer is offered improvement of their claimant's function (to reduce future insurable needs) by the provider. This "offer" is a tentative promise (pending approval), is submitted before acceptance, and has to be accepted by the client and insurer.

Lapse and Revocation: The client is provided the offer and the lapse period is ultimately determined by the offeror. If the claimant takes too long to respond, the offeror could withdraw the proposal. Once the client accepts, the offer is then provided to the insurer who has 10 business days to respond. The SABS clearly indicates that should the insurer fail to respond, the offer is deemed accepted and the services can proceed. However, even with assumed approval, the insurer can still deny the plan after the 10 days, at which time treatment is to cease. The client and offeror can revoke the plan at any time before (or after) acceptance, however the insurer can only revoke an approved plan by providing supporting rationale.

Acceptance: "The moment a contract is formed is by acceptance of an offer, each party is bound to its terms" (6 p. 122). The client is able to accept the offer for the services and agrees to the costs, but cannot actually pay for them without insurer acceptance. The insurer's decision to accept is based on them opining the services are necessary, and the costs reasonable. There are many ways they make this decision, and the decision is not always just. As mentioned, the insurer has three options with the submitted OCF 18. They can accept this in full, partially approve, or deny it. It would seem that a full approval becomes a binding offer to the client (we will use your money to pay) and offeror (you will get paid). A partial approval becomes a counter offer, and the offeror can either accept (start services) or refuse. A denial signals the offeror that approval has not been granted and if they proceed with treatment anyway, they will not be paid. However, if the insurer denies funding, they are, in most instances, to set up a second opinion, asking another professional to comment on the necessity and reasonableness of the submitted plan.

Consideration: An OCF 18 involves consideration of all three parties. The offeror is giving up time and expertise in providing services to the client. The client is giving up time, effort, and rehabilitation monies to receive the services. What is the insurer giving up? Profitability, lost adjuster work time to process the paperwork, issue payments, and claim monies, but the courts may not see this as consideration.

Intention to create a legal relations: By obtaining a client's signature on the plan, and receiving insurer approval, the essential terms have been accepted by all three parties. In the minds of the provider and client, this includes the creation of a legally binding relationship to provide and receive the services, respectively. For payment, the client, insurer and provider all understand that payment will be made to the provider by the insurer directly. However, when insurers do not want to issue payment (claimant is out of money or they have settled the claim after approval of the plan), they state that this "contact" is not binding between them and the provider (offeror), only between them and the claimant. This is a bizarre stance as the provider is required to follow all the rules (dictated by FSCO) in submitting the form, and should this be tried, it would seem that the court would "presume that the parties to [this] contract intended [it] to be legally bound" (6 p. 148) .

Capacity: By entering into this contract with the client and the insurer, it assumes that the client (or guardian or POA) has capacity to understand and "accept" the contract, and that the insurer (via a claim's adjuster) has the capacity to respond and "accept". There is risk to both the offeror and insurer that a disabled person could state later that they did not have legal capacity to enter into the contract in the first place, creating contract issues for all parties.

Legality: Surely a court would find the OCF 18 a legal and binding document, but the question is, between whom? Is the contract legally binding between the insurer and client ("we will give your money to a provider on your behalf"), or between client and provider ("I will pay you via my insurer for the services I agree to receive"), or between the insurer and provider ("we will pay for the services from the client's rehabilitation monies because it is in our best interest to do so")? It would seem strange for this "contract" to be considered legal between provider and client, when the client cannot fully accept it.

Certainty: The OCF 18 is not uncertain. The sections are clear, concise and cover all the requirements of the statute. The client, provider, and insurer all sign before the contract is enacted.

Privy to contract: The issue of privy to contract relates to the question of "between whom is the contract binding"? If the contract is between the insurer and client, then the provider cannot enforce payment from the insurer as the provider is not privy to the contract in the first place.

As per a personal experience in Small Claim's Court, the issue of OCF 18 as a contract between provider and insurer has not been tried. There are two cases that address similar aspects of this issue, but these are not comparable to an insurer paying a provider from an approved plan that lacks conditions. In 1489018 Ont Ltd (a rehabilitation company) v. Royal & Sunalliance, the Plaintiff sued the insurer for outstanding monies owed on treatment provided. 1489018 Ont Ltd. had submitted treatment plans and these were approved. However, they were to bill any other insurers before requesting payment from Royal and Sunalliance and failed to do so. When bringing an action against RSA, this was dismissed as "third parties have no say in any disputes between an insured and the insurer under the Insurance Act. The company must obtain an action against the claimant first". Further, the letter approving the services from RSA was "not a binding contract, because it included a condition precedent…which the company failed to do" (18). In MedCentra Inc. v. Economical, MedCentra sued for payments on MRIs provided to claimants pursuant to "direct billing provisions set out in Section 44 of the SABS". The motion was dismissed as "the plaintiff had no right to bring an action directly against the insurance company for payment for the examinations…there was no contractual relationship between the insurance company and the plaintiff and no basis to relax the doctrine of privy to contract". If the plaintiff had a cause of action, it must seek payment from the persons from whom it had a contract, namely, those who received the MRI examinations" (19).

None of these cases address the situation whereby the plan is approved without conditions, services are provided, and the provider is not paid. However, if the OCF 18 is not a contract between provider and insurer, then its' use seems futile and providers need to find other channels to secure payment.

Canadian Charter

"The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect…to the extent that a statute offends a right in the Charter, the statute will be declared invalid" (6 p. 14). The Constitution requires people be provided "the freedom of peaceful assembly", "the right to be secure against unreasonable search or seizure" and the right "not to be subjected to any cruel and unusual treatment or punishment", and precludes any "law, program or activity that has at its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of…age, mental or physical disability" (6 p. 16). So, considering this in relation to the problematic industry issues reported earlier, how are Ontario auto insurer's contractually able to behave as they are? How are insurers able to put people on such excessive surveillance that they fear leaving their home and develop significant psychological problems? How are insurers able to "force" a claimant to be profusely assessed by professionals not of their choosing and / or that may be unqualified? How can an insurer disadvantage a disabled person for 2.5 years by withholding income? Or, deny 16 of 21 recommended treatments, or suggest that a client must amputate her leg? How can FSCO get away with a 2 year delay in arbitration, knowing that for every day that is passing a disabled person is without treatment, income or benefits? The system also promotes ageism in that a 2 year old with catastrophic injuries has the same benefits as an 80 year old when the 80 year old will never live long enough to receive them, whilst the child will likely run out before they become an adult. These significant systems issues are at the forefront of concern for claimants and providers in Ontario's auto insurance climate. More case law is needed to set precedent for the behavior of insurers, adjusters, and assessing professionals to influence change.

Recommendations

The insurance industry in Ontario is a dog's breakfast. It is in one's best interest to drive, walk and bike safely. However, we need insurers, need to drive, and need to make sure that the system is sustainable. This is a delicate balance. While the government, public and insurance companies are crying about rates and profitability, the claimants are suffering more so due to insurer mistreatment, rogue assessments, delays and denials. The providers are suffering from poor support from the assessment community, and get "stiffed" by insurers on approved treatment plans. There are many stakeholders looking at solutions, and with my insider and biased perspective, I offer the following:

Assessments - The insurance examination process is not "independent" and bias needs to be removed. This could be accomplished through a blind referral system, or via a roster of qualified professionals that are chosen at random based on a sophisticated algorithm. Insurers should be unable to influence the provider chosen for examinations, clients should be given some choice, and companies and providers should be unable to impact insurer referrals by producing poor reports (or via questionable marketing activities). Then, should the report or credentials of a professional be discredited by the courts, or they are deemed to violate the rules of their regulatory body, they should be removed from the roster. Further, Rule 21 needs to be amended whereby third party hired "professionals" are not "immune" in law from poor assessments, opinions and reports. As society's values change, people are becoming less tolerant of unqualified people making a living from poor opinions, and new law needs to follow.

Insurer Accountability – Insurance companies need to stop blaming the public, fraud, professionals and lawyers for their financial issues. Instead, they need to look internally at their practices, and become proactive. This can be accomplished in three ways. First, they need to exercise more diligence when providing quotes and making contracts. Think of the process of applying for Life Insurance – medicals, blood and urine samples, health screening, etc. If auto insurers took more of a targeted and thorough

approach to insuring people, they will be in a better position to charge suitable rates per person, will have more pre-accident data to support (or not) a claim, and can screen for fraud potential. While this could increase the number of "uninsured drivers" who want to avoid the screening process, or whose rates will be astronomical due to poor health habits and behaviors, it will provide for more accurate adjusting. The second idea relates to this pointed question in a recent article: "How can we modify the law so that insurance companies are forced to provide the benefits they are contractually required to provide without forcing accident victims to retain a lawyer?" (20). If it is true that people venture to lawyers when their insurer treats them poorly, and lawyers increase claim costs, then the culture of insurance companies needs to change. Assuming they engage in diligence at the outset, they will be able to better support the 98% of people that are "good and honest" and whom have no intentions of abusing the system. Through support, not adversity, people will be more willing to work with their insurer on a positive outcome. It is when insurers deny, delay, confuse, or make claimants feel victimized or otherwise bullied that people turn to the legal profession who coaches them on how to "work" the system, drive up costs to improve settlement outcomes, and meet tort thresholds. Third, while settlement seems to "cure all evils" in the industry, insurers and adjusters that have acted negligent, violated the Charter, or failed a fiduciary duty need to have their day in court. Settling claims before the insurer is held accountable does nothing to improve the mistreatment in the system. Rather, I propose that even if the claim "settles" financially (freeing the claimant from the process and ongoing abuse), "bad faith" situations should be mandatorily tried to hold rogue parties accountable.

System Solutions - Considering the concern regarding Charter Violations, insurer's also need to employ reasonable practices around surveillance and assessment and the current delays for mediation and arbitration need to be resolved. Without improving these current problems, insurers are arguably "ruining peaceful assembly", causing "unreasonable search or seizure", and engaging in "cruel and unusual treatment or punishment" all to "ameliorate the conditions of disadvantaged individuals".

Amendments to the SABS should also reduce ageism whereby benefits are adjusted for age at the time of loss, to allow young injured people with the equal opportunity to recover.

Professionals – Professional associations and Colleges need to take a more aggressive stance on complaints rendered on third party assessments. If the law is holding assessors "immune", then the Colleges need to enforce accountability. Third party guidelines for insurance examinations need to be created to help professionals understand that while they are not creating a treating relationship per se, they are still required to practice within their scope and expertise, and need to recognize the significance of their power. For treating professionals, steps need to be taken to prevent contract issues around the OCF 18 and payment. Client's need to be clearly explained that ultimately "they" are paying for the services and that should the insurer default on their agreement to pay, the client will ultimately be responsible. Or, forget the OCF 18 altogether as if it does not form a binding contract with an insurer, then its use and submission should not be mandated, and the significant time and money costs to the system to complete this bogus form will be saved.

In closing, affordability should be the least of the worries of FSCO, IBC and the public. While rates are high, people are paying them. What the system needs is some insurer and adjuster accountability for how people are being treated at the time of claim, some professional accountability for third party assessments, contract and statutory revisions, and some support from the law to stop the unfortunate mistreatment of the honest and disabled people who thought they would be supported, not abused, at the time of claim.

Works Cited

1. **Ontario, Financial Services Commission of.** Legislation: Acts and Regulations. [Online] July 11, 2013. [Cited: October 17, 2013.] http://www.fsco.gov.on.ca/en/about/Pages/legislation.aspx.

2. **Sharon Tennyson, Mary Kelly, Anne Kleffner.** *The Design of Auto Insurance Systems: Research and Implications for Ontario.* Waterloo : s.n., August 23, 2012.

3. **Canada, Insurance Bureau of.** Insurance Bureau of Canada. [Online] 2013. [Cited: October 17, 2013.] http://www.ibc.ca/en/About_Us/index.asp.

4. **Ontario, Financial Services Commission.** *Auto Insurance Regulatory Oversight.* Toronto : Financial Services Commission of Ontario, 2011.

5. **Legislative Assembly of Ontario. *Committee Transcripts: Standing Committee on Finance and Economic Affairs - July 09, 2012 - Automobile insurance review.* [Online] 07 09, 2012. [Cited: 08 07, 2012.] http://www.ontla.on.ca/web/committee-proceedings/committee_transcripts_details.do?Date=2012-07-09&ParlCommID=8957&BillID=&Business=Automobile+insurance+review&locale=en&DocumentID=26491#P97_12552.**

6. J.E. Smyth, D.A Soberman, A.J. Easson, S.A. McGill. *The Law and Business Administration in Canada 13th Edition.* Don Mills Ontario : Pearson, 2013.

7. Monnex, TD Meloche. Automobile Insurance Policy. *Ontario Automobile Policy.* 2001.

8. Ontario, Province of. eLaws. *Unfair and Deceptive Practices Act.* [Online] June 1, 2013. [Cited: 10 17, 2013.] http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_000007_e.htm.

9. Francis, Brian. *Consumer.* October 25, 2013.

10. Harris, J. *McQueen vs Echelon Insurance.* 06-25901 and 07-35214, CanLII : Superior Court of Justice, 2009.

11. Shanoff, Alan. Toronto Sun. *Catastrophic impairment cases continue to vex insurers.* [Online] January 19, 2013. [Cited: November 2, 2013.]

12. —. Toronto Sun. *Adjusters forgetting ethics.* [Online] November 5, 2011. [Cited: November 2, 2013.] http://www.torontosun.com/2011/11/04/adjusters-forgetting-ethics.

13. Lane, J. *Lowe v. Guarantee Company of North America.* 3345, s.l. : Superior Court of Justice Ontario, 2003.

14. J, Power. *Worthman v. Assessmed.* 7038, Ontario Superior Court of Justice : Divisional Court, 2006.

15. Rule 21 - Determination of an Issue Before Trial Where Available. *Government of Ontario.* [Online] [Cited: November 5, 2013.] http://www.gov.pe.ca/courts/supreme/rules/annotated/a-rule21.pdf.

16. Killoran, Judith. *DB vs Economical.* FSCO A12-000632, Financial Services Commission of Ontario : Brantford, ON, 2013.

17. Shanoff, Alan. Toronto Sun. *"Amputate your leg" - Insurer's expert recommendation to accident victim.* [Online] October 26, 2013. [Cited: November 2, 2013.]

18. Killian, C.W. *1489018 Ontario Ltd. v. Vasile.* SC-04-002313-00, Toronto : Small Claim's Court, 2006.

19. Roberts, L.B. *MedCentra Inc. v. Economical.* 08-CV-348461 SR, Carswell Ontario : Ontario Superior Court of Justice, 2009.

20. Shanoff, Alan. Opinion Columnists - Toronto Sun. *Unattainable Goal? CBA report details the "abysmal state of access to justice in Canada".* [Online] September 7, 2013. [Cited: 11 6, 2013.] http://www.torontosun.com/2013/09/06/unattainable-goal.

21. Canada, Government of. Justice Laws Website. *Consitution Act, 1982.* [Online] 10 11, 2013. [Cited: 10 17, 2013.] http://laws-lois.justice.gc.ca/eng/const/page-15.html.

22. Shanhoff, Alan. Toronto Sun. *Accident victims deserve better.* [Online] January 8, 2012. [Cited: November 2, 2013.]

23. Akazaki, R. Lee. Adjuster Liability Claims: How to Avoid Them. How to Defend Them. *Without Prejudice.* October, 2013.