FAIR Association of Victims for Accident Insurance Reform (FAIR)

Response to:

Ontario Dispute Resolution System Review Interim Report

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Thank you for the opportunity to respond to the DRS Interim Report. Overall we see this report as a detailed review of our present circumstances and an excellent analysis of the problems with the system. We support the open discussion and many of the proposals that will speed up the system to ensure timely access.

September 2010 reforms have resulted in increased claims, higher costs and greater lengths of time waiting for hearings, all scenarios that work against recovery and delivery of treatments for accident victims. Our public health care has been drastically cut back at the same time as the denial rate for auto accident injuries went up, and MVA victims in Ontario are in crisis.

Our comments are those of the end users of the insurance product and our concerns are those of attaining wellness in as timely manner as possible. Insurance in Ontario is to provide the tools and coverage to protect injured drivers in their time of need. We find that insurance is no longer geared to achieve that goal and the concern to preserve and increase the insurance industry's profits has eclipsed the original purpose of purchasing the insurance product – in other words we are seen as a negative loss of income whom insurers would rather eliminate rather than customers who now require the promised services.

FSCO's Dispute Resolution System DRS

Accident victims know full well that there is no correlation between the date of the auto accident and the date a claimant applies for mediation. What the public is not aware of, and they should be, is that the claims process often does not end at Arbitration. A claimant can be successful at a hearing and remain in the system for many more years. We have several members who have had to retain a legal representative for nearly two decades at considerable personal expense.

There is a discouraging trend that can be seen in the graphs within the DRS Review Interim Report - when the legislation is changed to accommodate the insurance industry demands to decrease benefits, there is an increase in claims filed down the road. This is very troubling when considering the latest proposed change of limiting benefits to the catastrophically injured accident victims potentially coming into effect in the near future. There will be increased claims and those who are most injured will suffer the consequences of this unnecessary legislation that improves nothing except the profit line of Ontario's insurers. This will slow down the DRS system once again with changes that only Ontario's insurers support. Changes to coverage that will have a negative effect on those most seriously injured but also to our public health systems that are not equipped to offer the supports and care that accident victims require for recovery.

Treatment is the Most Common Disputed Issue

To find that 45% of the claims working their way through the FSCO Mediation system are for medical treatments is truly disturbing when one considers the personal cost to those thousands who are not getting the treatment or benefits they need.

Ontario's insurers have been calling consumers opportunists and fraudsters for years while the truth is that these benefits in dispute are those that will promote wellness and recovery. Rehabilitation has no opportunistic dollar value to a claimant. The value is in the recovery to an injured accident victim and yet accident victims are often accused of trying to 'enrich' themselves.

The volume of denied benefits in 2013 alone is astounding. We see the 25,329 injured accident victims who have applied for mediation based on a benefit denied by their insurer as a major crisis. Many of the treatments for trauma are not available in our public health system and the MVA victim is simply abandoned and ultimately loses the window of opportunity for timely treatment. This is counterproductive to society and the cuts to benefits, the delay and the denials, are standing in the way of an accident victims ability to return to as normal a life as possible. Coverage and security is the very intent of having insurance coverage.

The fact that 45% of those cases have been brought into dispute because an injured person has been denied medical benefits means that in this year alone (2013), 11,399 people waiting for mediation are without timely or appropriate medical treatment to aid in their recovery. Somehow these innocent accident victims have become victims to the war on fraud and had their claims denied.

The DRS internal database figures show the number one category of disputes at the Arbitration level suggests that at least another 5,000 people of the current 10,752 cases pending at that level are more MVA victims that are also without adequate treatment. This tells us that since December 2012, there are potentially over 16,000 people in Ontario who are unable to get the treatments and medical supports they need to recover from a car accident. An additional 25,521 injured accident victims have accessed the Superior Court of Justice because they too remain without adequate coverage of their expenses and treatments. This is unacceptable. This is not adequate coverage or an example of a system that is working for consumers.

Accessibility and Mandatory Mediation – Private vs. Public

The interim report discusses accessibility and the lack of timelines and how this plays out for accident victims financially but fails to address what this adversarial system is actually doing. Ontario's insurance policies and the failures of the ADR are punishing accident victims twice, causing additional harm, physically for those who go without treatment and emotionally with an adversarial system. The system itself is causing harm and that is adding to the cost of claims.

Accident victims are at the mercy of a system without timelines, deadlines, oversight and regulation enforcement. A point was missed here, that FSCO themselves played a role in trying to preserve the two year wait for Mediation and went to court in the attempt to do so. Our point is that the system is perpetually pointed away from the best interests of injured accident victims by all stakeholders, all of whom stand to benefit in some way.

A conflict was exposed in the 60 day rule for Mediation court challenge and again when it comes to the supply of proper forms and in the enforcement of the regulations. For that reason it may be better to separate the two arms of function at FSCO. Rather than to move the adjudication process to the private sector, it would be prudent to keep the process in the public realm. Justice is too easily bought and paid for, committees too easy to stack with biased representatives and the need for profit by private enterprise is an element that would affect function and delivery of the needed services.

Ontario's Arbitrators are well educated to deal with these complex cases and that expertise needs to be preserved if the system is to be operating smoothly. Privatization would not guarantee that that retention of trained Arbitrators would be a priority, nor would the system of qualifications to perform this complex job be necessarily always at the top of the list for a private company.

Proportionality

Accident victims are rightly sceptical about the paper review process when it comes to evaluating their injuries.

A process for hearings for hard goods that doesn't require an in person presence and that could be filed electronically would likely work well for claimants in respect to a mattress expense but a hearing regarding their injuries should always include personal participation of all the parties.

This is not to say that some hearings couldn't be held without the claimant's in-person attendance but it should always be the claimant's option to forgo their presence and not the system that shuts out their voice. At every other level, traffic court, small claims court, all of our systems are based on the right to appear in person before a judge to present their case. Were that privilege to be removed from the auto insurance dispute resolution process it would be to say that accident victims are not worthy of the same form of justice as any other citizen.

A future system that accommodates the differences between a simple case and one that is a dispute consisting of more complex injuries and issues would go a long way to expediting cases through the system at a lower cost. However, we feel that the $25,000.00 threshold that might deem any claim under that amount to be of lesser importance or not worthy of the same level of justice isn't right. It isn't taking into account the unpredictable nature of injuries as some disabilities only become apparent after some time - often what begins as a minor injury can end up as a more complex injury over time. This benchmark of $25,000 would relegate seriously injured accident victims to a level where they may not have access to an in-person hearing and that would unacceptable. We feel the threshold should be far lower, under $5,000.00 with the right retained to appear in person even if it were to be electronically done using video equipment.

Predictability and Neutral Benchmark

Such a process of access to medical information could be invaluable in speeding up the process by adding to the base knowledge of Arbitrators. However, we have reservations about who might be selected for a panel of experts given the bias of many of the medical evaluators in the system and the potential to 'slot' the injuries into categories without a hearing taking place.

Accessibility and Streamlining

The implementation of a program that would provide claimants with free advocacy services would be of assistance to those recovering small losses.

In an ideal world all accident victims would be able to access quality legal representation. The reality is that many cannot afford representation and those numbers are growing and there are more self represented litigants in the system.

The higher the denial rate, the more self-litigants are in the system and this will slow down the DRS system further unless litigants are assisted, not only in the basics of filling out forms but with aids to understand the way hearings are run so they can understand what is expected of them. We are very pleased to see this issue, at this stage, has been acknowledged and we look forward to improvement.

Self represented litigants who are also injured or impaired will require greater assistance in respect to case management and a longer time line to complete tasks to prepare for hearing. Accommodations should be built into the system for their needs and the timelines envisioned in the proposed framework would need to be adjusted in these circumstances.

Hearings will always rely on case law and we feel that Arbitration decisions should continue to be available to the public. With the ready exchange of information on the internet so wide-spread we think it is past time to consider anonomizing the injured accident victim names within these decisions. It's been made obvious to us that very few claimants are aware that their personal information about their claim is available on the internet.

Costs

The cost of legal representation is a big issue for MVA survivors who find themselves having to sue their insurer. For the most part, the costs awarded by the court are nowhere near sufficient relative to the amounts charged by PI lawyers. The payment inevitably comes out of funds meant for other purposes such as rehabilitation or other supports. This unfairly punishes an accident victim when an insurer wrongfully denies a claim. There should be greater penalties in place when an insurer is found to have deliberately ignored the facts in order to deny a claim. Claimants could then apply these funds to cover the costs of having to retain a legal representative in the first place when the claim was wrongfully denied.

Culture

If we are to fix this issue of backlog we need to go to the source of the dysfunction. Answer the how and why all these cases end up having to be mediated in the first place. We need to look at the problems of how the system mistreats claimants and denies their access to SABS by unfairly minimizing their injuries - because clearly half of all accident victims cannot be scammers and malingerers as the industry would have the public believe.

The 2011 Office of the Auditor General of Ontario (OAGO) pointed to the issue with the recommendation that FSCO "Improve its information-gathering to help explain why almost half of all injury claimants seek mediation, as well as how disputes are resolved, and to identify possible systemic problems with its SABS [Statutory Accidents Benefits Schedule] benefits policies that can be changed or clarified to help prevent disputes."

This speaks to the conflicting roles of FSCO function and plays into the problem of the failure to address the enduring systemic flaw of the use of partisan IMEs in the system.

We see two very fundamental problems that are affecting the volume of cases denied. One is the actions of individual adjusters and the lack of training and inconsistencies in claims handling practices that exists in that part of the industry. The second is the quality of the IMEs and the lack of independence and integrity or quality in these reports that are used to deny claims and delay treatment.

There are some well-trained adjusters in Ontario who do an excellent job but clearly when roughly half of the claims in the system are ultimately decided in favour of the claimant at a hearing years after the denial, it means that too often an adjuster has made an erroneous decision in denying benefits in the first place. Better training, guidelines and oversight are needed in this area.

There is no meaningful complaints process in place to address concerns about an adjuster. Claimants are totally dissatisfied with the process of dealing with adjusters who are unable or unwilling to do their job through an insurance company Ombudsman. There is no oversight or counteractive remedy that can be applied to correct the mistakes of a particular adjuster. One Adjuster, who will process hundreds of claims per year, could potentially be harmful to the system overall if left uncorrected. Internal checks and balances within the insurance companies are a good idea but the active involvement of claimants in that process might result in a negative outcome when they are exposed in this way.

Insurers and their adjusters, plaintiffs and their legal representatives all rely on the reports of independent medical examiners to evaluate injuries and define costs. Ontario's Triers-of-Fact, base their decision about eligibility to benefits on the conclusions contained in these opinions and evidence. All parties have an interest to see that the system that relies on IMEs plays its part to ensure that the quality of the medico-legal reports be of the highest possible standard. Both

sides have expressed concern about the quality of these examinations and the IBC has proposed on pgs 14,15,16 of their submission that a Medical Expert Panel be formed to, among other functions, be responsible to "report issues of competence and dishonesty to the appropriate medical college."

Another model for the delivery of quality IMEs, the Colorado Model (called the Personal Injury Protection Examination Program), offers a solution to the IME issues that have led to and contribute to the backlog of cases in our system.

Unlike the IBC proposition under Insurance Act R.S.O. 1990, c. I.8, s. 7, the oversight of the Colorado Model is a separate entity, and would operate outside of FSCO. This regulatory model is not part of the Arbitration Unit, nor would it offer advice to FSCO Arbitrators which could potentially influence the outcome of a particular case.

First introduced in 1997 the Colorado Model legislation requires that independent assessors be in the same specialty as the treating practitioner (including chiropractors, psychologists, or orthopaedic surgeons), and earn less than half their income from disability assessments. The process of assessor selection by agreement of both parties ensures that the assessor is acceptable to both the insurer and the plaintiff. It requires a level of cooperation.

Through the Personal Injury Protection Examination Program (PIP) Colorado cleaned up an IME process that was in crisis. Colorado's Insurance Commissioner contracted this task of oversight to an outside source to administer the program, create the IME provider register, process requests for examination and establish the reporting standards. The entire process from initiating the assessment to receipt of the IME report is designed to be completed within 45 days of the initial dispute. Colorado found this model of provision and oversight for IMEs so successful that they've kept it in place with some amendments after tossing out No-Fault auto insurance in 2003.

Ontario's IME process is fraught with bias and lack of oversight; consumers have no faith when attending an IME in Ontario that they will be given an acceptable quality report prepared by a competent and unbiased assessor. Given that almost all of these unresolved cases in the ADR system are the result of an IME report denying treatment or other benefits, removing the question of bias, quality and compliance from the IME process would surely take much of the adversarial components out of the court system. By introducing stringent guidelines and timelines governing IMEs, Ontario's Arbitrators would be able to hear cases with the knowledge that the evidence they rely on is prepared by assessors who meet the standards and conditions for membership of the PIP type or IME Review Panel.

Removal of an assessor (called a panel member in the Colorado Model) would be done by the Administrator of the program should the assessor fail to comply with the regulations. This would go a long way to restoring integrity to our system.

Ontario presently relies on the regulatory Colleges in Ontario to provide oversight for Third Party Assessors. The colleges, in particular the College of Physicians and Surgeons of Ontario (CPSO) have failed to be transparent in respect to the complaints that are brought about their physician members who perform for-hire medico-legal assessments. The lack of transparency to the public and the failure to hold member physicians accountable when accident victims are abused or sent to unqualified, biased or poor quality assessments can be seen on the latest posting on the CPSO's Transparency Principles Project website page.

The lack of relevant information and no accountability for Ontario's assessors makes ratemd.com the most likely place to get information about an assessor and that is not acceptable, nor is it reliable. Insurers are not checking up on their preferred assessors before sending claimants to examinations, legal representatives too often do not question the credentials of assessors at hearings, and claimants are kept in the dark - all of these factors work together to discredit the IME quality and to making the fair disposition of a claim more time consuming.

The IBC suggested that "Abusers of the system will be identified and appropriately reported by the panel members" but we need to make sure that the complaints are heard and dealt with and not dismissed at every turn as has been done in the past. Who would this IBC proposed Panel report the erroneous or abusive physician to – the College who refuses to take action or to inform the public? We would be no further ahead regarding the veracity of the IME reports on which the system relies.

The DAC system was created in order to clean up the problems with IMEs and to introduce standards and regulations to improve the system. It failed for several reasons, one of which was because the subcommittees, who set the standards, were soon poisoned by the same biased IME assessors exerting influence over the DAC process. The problem with poor quality IMEs and the 'experts' who provide their opinions to our courts predates No-Fault insurance. The dishonesty of this system survived the demise of the DACs and would still come into play even if we were to switch to a Public insurance system or a purely Tort system. Seriously injured claimants will never get fair treatment unless or until the quality of insurer assessments (IMEs) denying them policy benefits (including treatment benefits) finally improves and the system reconfigured to put some integrity back into the process.

The costs of running this parallel system of civil justice are far too high and there are too many claims wrongfully denied that are contributing to those costs. While insurers may say it is they who are paying the most dollars for this system, it is surely the unsuspecting taxpayer who is picking up the tab through our health and social systems and the innocent accident victim whose treatment or benefits are denied when they are labelled malingerers or fraudsters. The volume of claims in the system is a direct result of insurers looking to increase profit by denying claims and the reports of the insurance industry profits substantiate this.

Claimants do not decide lightly to go into debt so they can hire a lawyer and present a bogus case so they can scam the system. They are there because their insurer and the system failed them in a time of need. It is appalling to know that Ontario's insurers are using the terminology that claimants need to have "some skin in the game" when it comes to the costs of a claim at FSCO. Accident victims have plenty of 'skin in the game' both literally and figuratively when they've already lost something, sometimes limbs, sight, loss of jobs, loss of family, loss of control over their lives, a whole list of things which they must now deal with while being physically or cognitively impaired. Punishing accident victims by piling more costs and penalties on them will not improve the system but only serve to make it less fair.

Conclusion

In conclusion, we see many positive recommendations here to improve the system. Accident victims need substantive and systemic changes to how examinations are performed and an end to the abusive process that has added pressure to the adjudicative process. One cannot expect a system of justice to serve its purpose if the foundation on which it runs is dishonest. If the intent is to restrict the length and content of the medical reports as is suggested (pg 37), now is the time to talk about the quality of that medical evidence. Courts must always set the highest standards in order to be seen to do justice. Consumers expect the system to function without harming those injured on our roads and that the legal rights that are due all Ontarians will not be reduced simply because of involvement in a car accident.

We look forward to further discussions and consultation in respect to the recommendations.

FAIR Association of Victims for Accident Insurance Reform

Colorado DEPARTMENT OF REGULATORY AGENCIES, Division of Insurance, 3 CCR 702-5 AMENDED REGULATION 5-2-9 http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%225-2-9+Personal+Injury+Protection+Examination+Program.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251815030993&ssbinary=true

Public comments to the College of Physicians and Surgeons of Ontario (CPSO) Transparency Principals Project http://policyconsult.cpso.on.ca/?page_id=2420

Rules of Civil Procedure 4.1.01 (1) It is the duty of every expert engaged by or on behalf of a party to provide evidence in relation to a proceeding under these rules,

(a) to provide opinion evidence that is fair, objective and non-partisan;

(b) to provide opinion evidence that is related only to matters that are within the expert's area of expertise; and

(c) to provide such additional assistance as the court may reasonably require to determine a matter in issue.

Duty Prevails

(2) The duty in subrule (1) prevails over any obligation owed by the expert to the party by whom or on whose behalf he or she is engaged.