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Before you pass Bill 15, some things to consider

What do claimants want?

From a claimants perspective much of what is wrong with the system starts with the Insurance Act and that it is virtually impossible to decipher what you are or are not covered for. The present Statutory Accident Benefits Schedule (SABS) is over 60 pages long. Imagine reading that after a car accident while trying to recover.

The constant changes to the legislation make it a necessity to have legal representation to even fill out the forms correctly. Accident victims rely on the Insurance adjuster to provide them with correct information and this is problematic. Many insurers have no information on-line to assist their clients to make a claim and we note that the IBC also has no information to assist the consumer to understand the process. We asked at the DRS review that FSCO consider putting together a help line or process to assist MVA victims but it did not materialize. The message that we get from this lack of action is that no one understands the insurance product anymore and don't want to get involved in any process other than making profit.

The premium paying public knows nothing of the machine that insurance has become – they all believe that they will be covered if they need it. They will continue to believe this even after the vote on Bill 15 because no one will advise them that on Monday they had certain coverage and on Tuesday the coverage has changed. The public puts its trust in our representatives. Even while coverage is tripped away, people believe that our government is acting in THEIR best interests and not the interest of insurance companies.

Imagine how many claims will be turned down by Ontario's insurers going forward if insurers are off the hook for interest on overdue and unpaid SABS benefits like income replacement and rehabilitation or attendant care costs. This will inevitably lead to more cases in front of adjudicators, no matter what system is in place. Justice delayed is justice denied and with each change to Ontario's auto insurance legislation that causes delays (historically this is a fact) accident victims' rights to fairness are sacrificed for efficiency and cost savings that benefits only Ontario's insurers.

There are systemic problems that must be corrected or the dysfunction will simply be passed on and into a new system.

FAIR has appeared in front of the Anti-Fraud Task Force, the DRS Review, and in front of our legislators with the same suggestion to correct the delays in the system and the unjust treatment and bullying of

legitimate claimants that has led to the backlog in our courts. At every level there has been an acknowledgement of the problem but there has been no will to stop the abuse of victims.

For clarity in respect to our testimony at Queen's Park last week, I am attaching information on the Colorado Model of assessor selection. This is a system that the State of Colorado found so effective that, despite having long since disposed of their No-Fault auto insurance and having moved back into a Tort style of coverage, they have kept the roster system of assessor selection.

The Colorado Model relies on a roster of qualified medical practitioner assessors. When an accident victim requires a medical assessment for injuries an application is sent to the IME Program Administrator in charge of the roster. Both plaintiff and defence lawyers are sent a short list of only 5 names of approved and qualified assessors and from this list the two sides must agree on one single assessor to perform the assessment.

Inclusion on the roster is subject to qualification and adherence to the stringent time lines and rules and failure to comply will result in a name being taken off the roster. This system would go a long way to weeding out the bad apples and the fraudulent medical reports in the Ontario system.

This is not a resurrection of the Designated Assessment Centers (DACs) but it does hold assessors accountable and limit the amount of IMEs that accident victims will have to attend. This will promote interaction between the two opposing legal representatives and expedite claims when triers-of-fact don't have to sift through volumes of highly partisan 'independent' medical opinions. Ontario's biased medical opinions are at the core of the backlog and the expense of claims handling. Let's face it, without bona fide and reliable medical opinions about injuries – how can any accident victim expect justice? Or for that matter, how can insurers, who are also victims of this partisanship, be expected to handle claims fairly?

As it is now, the bulk of the reports in the system are slapped together piecemeal as there are no protocols in place, no template available and there is no regulatory oversight. In other words there is a complete lack of standards while the whole system in Ontario, from qualifying for the benefits to deciding the cases heard in court, relies on medical opinions and reports.

Oversight of assessors relies on the Colleges in Ontario. That too is not working and the media is full of negative coverage about CPSO and CPO college inaction when it comes to harming patients. What do you think is happening to vulnerable MVA victims who were seen at or received treatment at over 89,000 private offices and clinics just last year alone.

Wondering why you don't hear about many complaints about the bullying and abuse and why so many claims are turned down based on these medical reports. It's simple. The Colleges, on which the entire system is relying on to regulate the health professionals that work in the insurance industry, is a complete failure at protecting the public. There is no meaningful oversight of the assessors and it is a wild west of incompetence and bias. When accident victims complain, as they often do, the complaints are ignored, sloughed off or kept secret from the public. This isn't right and it benefits Ontario's insurers

who often knowingly use these practitioners to rid themselves of legitimate claims. As our government do you not have a duty to protect the public? Surely someone does.

It's already a done deal that half of all claims are turned down as a tactic to save the insurers money. Reducing the Prejudgment Interest to 1.3% will only add fuel to the fire. There needs to be more accountability, not less. Without anything to discourage them, insurers will be incentivized to systematically deny claims through the use of partisan medical reports prepared by their preferred medico-legal 'expert' assessors to deflate a claim.

There will be cries of fraud and malingering by insurers to prop up the denials, more victims will be unpaid and without treatment, more legal cases in our courts, more strain on our public systems, and ultimately more money for insurers.

All because, for some unknown reason, it's generally believed that honest and unbiased medical assessments of accident victims is a bad thing. The entire system would fall apart if victims were to know the extent of their injuries and seek treatment for them. Scamming accident victims by denying claims is really harming and intimidating victims until they go away and stop making claims. This costs victims valuable timely recovery and quite often their home and any savings they may have, it is an exercise in humiliation. And what does it cost insurers?

Last week legislators heard from the Aviva representative at the hearings on Bill 15. Most shocking is the fact that any insurer is paying out such substantial sums for defending against claims, 44 million dollars in just 2013 alone. This is just one insurance company paying an average of $7,719.30 in legal defence costs per claim - well above the average amount paid to claimants in 2013. See pg 24 of HCDB report where insurers paid out an average of $4745.00 ($3,934 - $5,557) to injured MVA victims in 2013. The amount paid to victims in the first 6 months of 2014 was a mere $1,790 per claim – meaning that the legal defence costs are now four times as much as the value of what a claimant gets from their insurer. http://www.ibc.ca/en/car_insurance/documents/facts/hcdb%20standard%20report%202014h1%20-%20final.pdf See pages 58 and 59.

So is there a cure for this dysfunctional and bullying insurance system we have? We don't know but we think that holding insurers accountable when claims are wrongfully denied and cleaning up the medical opinions (on which the denial is based) would be a positive first step.

Below is information on the Colorado Model of Assessors, a highly successful and cost saving program that just might move Ontario's insurance industry from a scandalously dishonest and bullying business model to a more functioning system.

If you reward Ontario's insurers existing bad behaviour by making it less costly to behave badly we will not be further ahead and the life of accident victims will be even more stressful and harmful. While we are sure that is not the legislator's intent, it certainly will be the result of passing Bill 15. Insurers will be less likely to stand behind their contracts and victims will be further victimized and marginalized without fair access to our courts – everything Ontario's insurers need to increase profits.

Thank you for your time and we hope you'll take a moment to remember that the purpose of insurance is to provide coverage and not just profit for insurance companies.

Rhona DesRoches,
FAIR, Board Chair
http://www.fairassociation.ca/

Aviva Canada It's important to put the legal disputes into perspective. I want to make it clear that neither the defence lawyers nor the plaintiff lawyers speak on behalf of Aviva Canada, or probably any of our other companion insurance companies. Legal expenses are a huge cost driver and they benefit very few people. In 2013, Aviva paid $44 million to its own lawyers to handle claims in dispute—that means either in litigation in the court system or in dispute through the FSCO DRS system. That is less than 0.1% of all of our customers. We have 570,000 customers. Only 0.1% of customers have disputes that generate $44 million just on our payment. That's leaving out the costs that are generated by the plaintiff—so lawyers and experts.

THE COLORADO MODEL OF ASSESSOR ROSTER

Easy to understand http://www.injuredworker.org/forum3/viewtopic.php?t=107

The regulations:
http://www.sos.state.co.us/CCR/SearchRuleDisplay.do?getEntireRule=yes&pageNumber=39&totalNumberOfResults=961&keyword=sheet&type=keywordSearch&contentId=1054391

Amended Regulation 5-2-9 - Personal Injury Protection Examination Program

Section 4 Rule

All statutory cites contained in this section reflecting § § 10-4-701 through 10-4-726, C.R.S. 2002, shall refer to the statutes in effect as of June 30, 2003.

A. DEFINITIONS

1. Claim: A request for payment of a PIP benefit submitted to the insurer on or after January 1, 1997 for which reasonable proof under Regulation 5-2-8 has been provided and which was not subject to an Independent Medical Examination (IME) prior to January 1, 1997.
2. Days: When referred to in this regulation shall mean business days.
3. Disputed PIP Claim: A claim, or any portion thereof, which the insurer is either investigating pursuant to Regulation 5-2-8 or gives notice that it is denying. A disputed PIP claim may include a claim the insurer is investigating, even though the insurer has paid or may be paying other claims for benefits.
4. IME Program Administrator: The person or entity selected by the Commissioner to administer the PIP examination program, whose name, business address and telephone number may be obtained from the Division of Insurance.

5. PIP Examination: Any in-person physical or psychological examination, unless other review of records or evaluation is appropriate and agreed to by the parties.

B. STANDARDS AND CONDITIONS FOR MEMBERSHIP ON THE PIP EXAMINATION REVIEW PANEL

An applicant for panel membership shall complete the PIP IME registration form as required by the IME Program Administrator. By submitting a completed registration form for panel membership to the IME Program Administrator, a health care practitioner certifies he/she:

1. is qualified to serve on the panel and shall abide by all applicable statutes, rules and regulations; and
2. is actively engaged in the practice of his/her profession as defined in § 10-4-706(6)(c), C.R.S. 2002; and
3. shall personally perform a PIP examination when selected; and
4. shall promptly notify the parties to the claim of any circumstances that, in his/her judgment, constitute a conflict of interest with respect to a particular claim; and
5. shall promptly notify the IME Program Administrator of any circumstances that might disqualify the individual from panel membership in general; and
6. upon notification of being selected as an examiner for a particular claim, shall schedule the PIP examination to occur no later than fifteen (15) days from receipt of written notification, unless the parties consent to a later date; and
7. shall complete the IME report and "IME Report Summary Sheet" prescribed by the Commissioner within fifteen (15) days after the PIP examination appointment; and
8. is familiar with the provisions of § 10-4-706(6), C.R.S. 2002, and the provisions of this regulation applicable to panel members; and
9. consents to the terms and conditions set forth in § § 10-16-601 through 10-16-606, C.R.S., regardless of whether he/she is a "doctor" as defined in § 10-16-602(1), C.R.S.; and
10. shall not become a treating provider for the PIP claimant; and
11. shall perform the PIP examination in an impartial and objective manner; and
12. shall promptly respond to a request from a party to a PIP claim for copies of records from a previous PIP examination performed by such panel member regarding such claim; and
13. shall promptly notify the IME Program Administrator of any changes in information on his/her membership application, including fees.

Failure to comply with these provisions may result in removal of the panel member from membership on the PIP Examination Review Panel by the IME Program Administrator.

C. REQUESTING A PIP EXAMINATION

1. A party to a PIP claim may request a PIP examination when there is a disputed claim or when the party is dissatisfied with the findings, opinions and conclusions of a PIP review panel member. An insurer, other than an insurer using a managed care plan, shall obtain any PIP examination through the PIP examination program.
2. The requesting party shall submit a request to the IME Program Administrator on a form titled, "IME Request Form," prescribed by the Commissioner. The completed request form may be mailed or faxed to the IME Program Administrator. Concurrently, the requester shall notify the other party and the treating provider whose care is to be reviewed, of the request.
3. The requesting party shall specify the professional specialty of the health care practitioner who will perform the PIP examination. Where practical, such professional specialty shall be the same as that of the treating health care practitioner whose treatment, opinions, diagnosis, plan of treatment, prognosis, statement of causation, or recommendations are intended to be reviewed; except that psychiatrists, psychologists, and neuropsychologists may review one another's treatment and opinions to the extent that the reviewing expert is qualified to address the specific issues which arise in a particular case.

4. In those circumstances in which several professional specialties are treating the injured party for the same injury whose treatments and opinions are sought to be reviewed in an IME, the requesting party shall designate the professional specialty of the particular health care practitioner whose treatment and opinions are intended to be reviewed.
5. In those circumstances where a PIP examination report recommends future treatment, the requesting party may designate the same PIP examiner who made such recommendations to perform a subsequent PIP examination or the requesting party may request a list of five PIP examiners as set forth in section 3.D.1.
6. An injured party under a managed care plan may request a PIP examination only after exhausting all internal grievance and review procedures available under the managed care plan. Once all internal grievance and review procedures have been exhausted, the insurer shall provide written notice to the injured party of the injured party's right to seek a PIP examination. In the event that no internal grievance and review procedures are available under the managed care plan, the injured party has the right to request a PIP examination upon denial of the claim by the insurer.
7. If an injured party who elected to receive benefits pursuant to a managed care plan chooses to be treated exclusively outside the network, the PIP benefits are no longer being provided through a managed care arrangement and the insurer is entitled to obtain a PIP IME. Treatment exclusively outside the network means treatment the injured party elects to receive outside the network, after treating both inside and outside the network for a period of time, without returning to a network provider.
D. SELECTION OF THE PANEL MEMBER AND PREPARATION OF RECORDS
1. Upon receipt of a completed “IME Request Form” , the IME Program Administrator shall prepare a list of five panel members using a revolving selection process based on the practice specialty requested and taking into account the geographical location of the claimant. Incomplete request forms may be returned to the requester by the IME Program Administrator and the selection postponed until a complete form is submitted. If the parties agree that a specific health care practitioner shall perform the PIP examination, rendering the list unnecessary, the insurer shall prepare a “Request For IME” form and a “Notice of IME” form and send them to the IME Program Administrator and the claimant. The selected health care practitioner shall be required to complete and submit the “PIP IME Report Summary Sheet” as prescribed by the Commissioner. If the injured party is residing outside the State of Colorado, the IME requester has the option to pay all reasonable expenses to bring the injured party back to the State of Colorado for the PIP examination, or. select a licensed practitioner of the same specialty as the treating practitioner if available, and agreed upon by both parties, in the state in which the injured party resides.
2. No later than five days after receipt of the completed IME Request Form, the IME Program Administrator shall transmit the list of five panel member names to the requester by mail or fax. The IME Program Administrator shall include with the list a copy of each panel member's completed information forms.
3. Within five days after receiving the list of panel member names, the requester shall strike through two names on the list and forward the list, together with the application forms corresponding to the remaining names on the list, to the opposing party, by fax or by mail. Concurrently:
a. if the requester is the insurer, the insurer shall also send to the claimant an index of the records relevant to the disputed claim. The insurer shall denote which of the records it intends to submit to the selected panel member, listing the records in reverse chronological order (most recent first) and identifying the date and general nature of each record;
b. if the requester is the claimant, the claimant shall notify the insurer whether such claimant elects to have the insurer prepare the records file. If the claimant so elects, the insurer shall, promptly furnish the claimant with an index of the records in the insurer's file relevant to the

disputed claim and the claimant shall promptly return to the insurer copies of any additional records, not already identified on the insurer's index, to be included for the PIP examination. All records identified by the insurer and any additional records identified by the claimant will be submitted to the panel member. If the claimant does not elect to have the insurer prepare the records, the claimant shall send to the insurer an index of the records he/she intends to submit for the PIP examination, listing the records in reverse chronological order and identifying the date and general nature of each record.,

c. The requester of the PIP examination shall telephone the other party to confirm the other party's actual receipt of the list and all enclosed materials.

d. All communication from the treating practitioner, the claimant, the claimant's representative, the insurer or the insurer's representative to the PIP examiner or concerning the PIP examination shall be in writing with copies sent to the other parties.

4. Within five days after actual receipt of the list of names from the requester, the other party shall strike through two of the names remaining on the list and return the list, reflecting both parties' strikes, to the IME Program Administrator and provide a copy to the requester. Concurrently:

a. If the requesting party is the insurer the claimant shall send to the requester copies of all records the claimant intends to submit to the selected panel member, that are not already identified on the requester's index of records. The claimant's records shall be in reverse chronological order to enable the requester to compile a complete file for submission to the selected panel member in accordance with section 3. E. 2. of this regulation.

b. If the requesting party is a claimant who has elected to have the insurer prepare the records, such insurer shall follow the procedures set forth in Section 3. E. 2. of this regulation for submitting the records to the selected panel member. If the requester (claimant) has not so elected, the insurer shall send to the requester copies of all records the insurer intends for submission to the selected panel member, that are not already identified on the requester's index of records. Such records shall be in reverse chronological order to enable the requester to compile a complete file for submission to the selected panel member in accordance with section 3. E. 2. of this regulation.

5. The parties shall make every effort to avoid duplication of records submitted to the selected panel member, however, the party preparing the records for submission shall not omit any record whatsoever without obtaining the written consent of the other party. Parties may supplement the records file through the party preparing such file, but only within the time period established in section 3. E. 2. of this regulation.

6. Unless both parties agree otherwise, the failure of a party to forward the list of panel member names within that party's designated time period shall result in forfeiture of such party's right to strike names from the list. Upon being notified and confirming that such forfeiture has occurred, the IMB Program Administrator shall select-two of the remaining names on the list to be stricken.

7. To obtain a subsequent PIP examination, the party requesting the subsequent PIP examination shall follow the procedures set forth above in this regulation for requesting PIP examinations.

8. If the selected panel member knows of or becomes aware of any conflict that may prevent him/her from rendering an impartial and objective evaluation, the panel member shall notify the IMB Program Administrator and an additional name will be provided to the parties to allow the selection process to be repeated.

E. SCHEDULING THE PIP EXAMINATION AND SUBMISSION OF RECORDS

1. Upon receipt of the list indicating the name of the panel member selected, the insurer shall promptly complete the “Notice of PIP IME” as prescribed by the Commissioner and shall send the completed notice to the parties, the selected panel member, and the treating provider under review. The selected panel member shall schedule the PIP examination to occur within fifteen

(15) days after actual receipt of the notice (see section 3. B. 6.), unless the parties agree to a later date, and the panel member shall notify the parties of the date, time and location of the PIP examination. If the selected panel member cannot schedule the PIP examination within fifteen (15) days and the parties cannot agree on a later date, either party may request that the selected panel member be disqualified and a new name be provided by the IME Program Administrator. A specific date shall be set, even if, by mutual agreement of the parties, only a review of records is sought. If the parties have agreed upon a health care practitioner without necessity of the list of names, the insurer shall prepare the "Request for PIP IME" and the "Notice of PIP IME" and send them to the IME Program Administrator. If the PIP examination is a reevaluation by the same PIP examiner who previously performed the PIP examination, the party requesting the reevaluation shall notify the other parties including the IME Administrator that a reevaluation is being requested with the date of the reevaluation and an index of additional records shall be provided pursuant to Section 3. D. The notification to the ME Administrator shall be made by submitting a fully completed PIP IME Request form. The provision of reevaluations by the same PIP examiner who previously performed the PIP examination shall apply to all reevaluations requested on or after the effective date of this regulation.

2. Once the PIP examination is scheduled, no later than ten (10) days prior to the date of the PIP examination, the requester or the party preparing the records (if not the requester) shall:

a. prepare an index of the records to be affixed to the front of the records file, identifying the name of the PIP claimant, as well as the date and general nature of each record in reverse chronological order; and

b. transmit the index of records, and the complete records file to the selected panel member; and

c. transmit copies of the index of records to the opposing party and to the treating provider under review.

3. A PIP examination, once requested, shall not be withdrawn unless the parties agree or the disputed claim is resolved.

4. Except in cases of unforeseen or emergency events, if a claimant fails to appear for a PIP examination or does not cancel the appointment at least three (3) business days prior to the scheduled date and time of the PIP examination, the claimant shall pay a reasonable "no-show" fee, if applicable, and reschedule the PIP examination to be completed within fifteen 15 days after the initial scheduled date of the PIP examination. The selected panel member shall notify the requester that the claimant did not appear for the PIP examination and if the claimant rescheduled the examination the date of the PIP examination. If the claimant fails to reschedule the PIP examination, fails to cancel the rescheduled PIP examination at least twenty-four (24) hours in advance, or fails to appear at such examination, then (1) the PIP examiner may, at the option of the insurer, conduct the examination based on the records submitted by the parties and render an opinion based solely on the records, or (2) the insurer may deny coverage on all or part of the claim for benefits. This section is not intended to alter any terms of the contract between the insurer and insured regarding their respective rights, duties, and obligations and the law involving such matters.

F. REPORT BY PIP EXAMINER

1. No later than fifteen (15) days following the date of the PIP examination appointment, the selected panel member shall complete his/her written report and the "IME Report Summary Sheet" as prescribed by the Commissioner. The selected panel member shall transmit a copy of the completed IME Report Summary Sheet to the IME Program Administrator, and shall transmit copies of both the full report and the completed IME Report Summary Sheet to the persons identified on the Notice of PIP IME as authorized to receive the report on behalf of each party. The selected panel member is not required to send the IME report to more than two such individuals, one for the requester and one for the other party. The requester shall promptly

transmit a copy of the full report and the “IME Report Summary Sheet” to the treating provider whose care was reviewed by the PIP examiner.
2. The report shall address all issues relevant to the examiner's findings with respect to the disputed claim, including, if applicable, but not limited to: reasonableness, necessity, causation, apportionment, diagnosis, prognosis, plan of treatment, need for essential services, ability to work, opinions and recommendations.
3. Questions regarding the content or completeness of the PIP examination, report and IME Report Summary Sheet shall be directed to the panel member.