



FAIR Association of Victims for Accident Insurance Reform

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FAIR response to:

Fair Benefits Fairly Delivered
A Review of the Auto Insurance System in Ontario

September 15, 2017

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FAIR Association of Victims for Accident Insurance Reform is a grass-roots, not-for-profit organization of car accident victims and their supporters. Thank you for the opportunity to have our voices heard in respect to the changes to auto insurance proposed in Fair Benefits, Fairly Delivered.

It is unfortunate that the report data is not more up to date as there have been significant changes to auto insurance that have not been considered. The cuts to coverage in recent years, a new LAT hearing system has come into play, and overall the number of accident claims in Ontario has fallen. Insurers are paying less out in claims, premiums have not been significantly reduced, and there are consistently too many claims in the system.

It is agreed by all stakeholders that auto insurance in Ontario is broken and that the Insurance Act no longer serves victims needs and, as pointed out on page 9 of the report, this is a structural flaw in the system. Consumers believe that we have for-profit insurance coverage while the reality is that we now have taxpayers paying increased costs for accident victims through public supports as insurers continue to cut coverage. In fact, we are paying higher premiums for far less coverage. Insurers have increased their efforts to control costs through claims denials while bolstering profits by creating legislated threshold obstacles for victims to access recovery resources with the creation of the CAT designation and the Minor Injury Guideline (MIG).

The public and the government know little to nothing about insurer profits and what they do with our premium dollars. This is very much a concern when it comes to the quality of coverage. We only know what insurers tell us about their finances and there's no transparency and so no ability to find out. That's a big gap in knowledge when making decisions about coverage that will affect the treatment of tens of thousands of Ontario's traumatically injured patients every year.

If the goal is for the "government to provide a guaranteed safety net for those injured in auto accidents" then why are we using the insurer model and not our own patient model? If recovery is the driver behind the proposed changes then the perspective must change too. Accident victims must be seen and treated as the patients they are, the traumatically injured whose lives are turned upside down by a sudden and unexpected event.

We sense that this changed view of accident victims is the centerpiece of the Fair Benefits, Fairly Delivered report and that maximum medical recovery is the goal. We agree with that and our answers below reflect that MVA victims be treated as patients, not clients, and that they have a right to have their own chosen medical professional make healthcare decisions with their input. The insurer role should be one of facilitation of the services needed for recovery. We trust our doctors and public system to assist us to make good choices. We do not trust insurers or their medical professionals who owe victims no duty of care to put our recovery interests first and before the insurers' bottom line. In other words, we trust the public system and not insurer created programs of care. Insurer medical examinations (IMEs) do not facilitate recovery but focus instead on whether insurers are obligated to pay. Insurers put victims through excessive IMEs and spend more assessing than treating victims and the

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poor quality of these medical reports are behind the volume of cases at FSCO, the LAT and in our civil courts.

There is considerable concern in this report about how few dollars are reaching accident victims who quickly are impoverished in the present system. Consideration and attention should be paid to how victims now have to shoulder legal costs at the Licence Appeal Tribunal (LAT). We are not just talking about the cost of representation; we are speaking of how victims are expected to pay the legal cost of holding their errant insurer to account. That needs to change and we think the LAT system didn't get the attention it should have in this report. If the concern is about too few dollars reaching victims then the system must ensure that recovery dollars don't end up disappearing into legal costs that the insurer created through wrongful denials.

We would point out as well that the Tort deductible and a low pre-judgment interest (PJI) rate on monies owed to victims by insurers is also playing into fewer dollars going to MVA victims and that means fewer dollars going toward recovery. Both the deductible and the PJI serve to punish MVA victims financially while advantaging wealthy insurers.

The government has a responsibility to all Ontarians who purchase car insurance to ensure that victims are covered by a system that puts their medical recovery as a priority. The government isn't a partner with insurance companies; the government's interest should be Ontarians and their needs.

The first step is acknowledging the problem and the second step is to see and treat MVA victims as patients, not clients, and to create a system that serves their recovery.

Below are our responses to the various recommendations.

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Response to Recommendations

1. The government should not move to a government-run auto insurance system at this time. There is an opportunity to learn from past experience and fix the problems in the current auto insurance delivery system in Ontario as described in this report.

This is no longer No-Fault private insurers blended with Tort. This is public/private for-profit/limited Tort system. We are already part of the way to public insurance since insurers no longer pay for many expenses and have limited the time to collect med/rehab benefits from 10 years to 5 years. Insurers also recently significantly reduced the time non-earner benefits can be collected to a mere 2 years. This is a serious deficit for students and young people who are injured and this does mean that those individuals will become the responsibility of the taxpayers of Ontario. It is time to address the public's financial participation in caring for car accident victims – they may not know that they are on the hook when insurers are slashing coverage and/or narrowing access to resources for victims. We do not know the ratio of the costs for MVA victims to the taxpayers vs. what the insurers are currently paying but we should know that information in order to know whether privately run insurance is viable or where the tipping point might lie.

2. Ontario's current no-fault benefits should not be reduced.

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The question should be asked, are the current benefits adequate in relation to the current costs of recovery? We are underinsured, partly because income replacement has not kept up with inflation. The court 'deductible' of roughly \$37,000 victims may have to pay for Tort and pre-judgement interest (PJI) on money an insurer owes to a MVA victim who is successful in proving their injuries, has been adjusted to inflation - why hasn't income replacement, now stuck at \$400 week, still unchanged for over a decade, been adjusted? This amount is below the poverty line and not in line with the average wage in Ontario. This creates economic hardship and stress for injured victims in recovery, especially those who are making minimum wage or who have dependents in their households.

3. The regulator should undertake serious discussions with the Ministry of Health and Long-Term Care to develop a service for lifetime management of care for seriously injured accident victims. Eventually, as the province develops this expertise, the expertise and even services could expand to address other injuries outside of the auto insurance system. This would allow for continuing improvements in care to develop and recommendations for preventative measures to be generated while ensuring that patients are being treated by a reliable and sustainable system.

Ministry of Health should be called in to deal with quality of services to MVA victims who ought to be classified as 'patients' in the health care system - including at the College regulatory oversight level. Victims should be patients and not third-party 'clients' if the desire is to fairly treat injured victims and the focus is recovery. Insurers must step back from the adversarial role, and treat their customers as patients seeking treatment and support. The system must also make that shift and greater attention should be put on the regulatory Colleges who have adopted Third Party vendor regulation but are failing to provide the enforcement.

All injured people in Ontario should have the same right to quality medical care that addresses their concerns and works towards wellness. It shouldn't matter if you fell in your kitchen or got hurt in a car crash, the desired outcome is the same. The existing system where injured Ontarians are treated as clients rather than patients must change. If a family doctor was to diagnose a patient as having kidney failure and sent that person for treatment at with a qualified practitioner, that patient would not expect that OHIP would try to interfere or was trying to save money and so would concoct a reason to say that their kidney was just fine, take OHIP to court if you disagree. In Ontario when a treating health practitioner recommends treatment for an accident victim there is often the IME happening between the recommendation and the treatment. Too often treatment is denied and this is where and how insurers increase profits. Delay and deny aptly describes how insurers view treatment for accident victims. The interference of the poor quality or partisan insurer medical examination stands as the biggest obstacle to accessing treatment.

You have to wonder why the insurance system won't trust your family physician or treatment provider. They, after all, have an interest in your recovery and don't get paid 'extra' to deny you have a problem. Patients tend to trust their family doctor with all other aspects of their health, why can't the system trust their doctor, or their dentist, or their physiotherapist too? These are the healthcare practitioners who do have a duty of care to patients, who work long hours and are invested in their communities; they are in the business of saving lives, curing diseases and guiding their patients through illnesses. Why are the futures of these injured accident victims put in the hands of physicians who often don't even treat patients and work solely for insurance companies? It just doesn't make sense but it does mean that accident victims are double-doctoring in a sense because they can't trust the insurer doctors to accurately state what is wrong with them and what they must do to achieve best possible recovery.

The government and insurers have consistently used these same third-party medical opinion vendors as consultants to make legislative changes and pathways of care that have harmed victim recovery.

A lifetime of care under the thumb of an auto insurer is a nightmare of constant undermining of treatments prescribed by healthcare professionals and virtually guarantees that an MVA victim will have to have a legal representative on speed-dial indefinitely.

4. There should be a minimum of disputes and delays in accessing single lump-sum awards for those who are catastrophically injured. Such awards, should be efficiently and quickly determined by an independent examination centre and based on objective measures, such as the American Medical Association guide, supplemented, where appropriate, by specialized and well-established guidelines.

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Stakeholder input needed as there is some dissension on what guidelines work best in this situation re thresholds MIG and CAT

5. Insurers should make sure that seriously injured persons are given top priority and do not need to hire lawyers or other professionals to get their entitlement.

As long as adjusters have so little knowledge about injuries and medical conditions, there will continue to be disputes about coverage. This is a front-line issue for insurers who need better trained professionals to adjust claims. There should be unquestioned reliance on treating health practitioners to lead the way on what the patient needs for recovery at the outset of the claim.

6. The regulator should move as quickly as possible to create programs of care for the most common types of automobile injuries. The programs should be based on the evidence based findings of the Common Traffic Injury Guidelines.

That insurers desire to control costs is apparent in the CTI report which we see as putting significant obstacles in the recovery path. This 'new' study that cost 2.8 million dollars looked at as mere 11 MVA victims for less than 6 months and as a result didn't provide any data on outcomes. And it is the outcome that matters if injured MVA victims are not to become a financial burden for insurers and taxpayers. CTI will restrict access to many treatments currently available to victims by slotting them into a box and streaming them through prescribed treatments regardless of age or individual needs. As a consequence many treatment providers will see themselves in conflict with their College guidelines or with limits on their ability to treat victims. If you ignore the 'streaming' part of CTI what you are left with is fewer options for victim recovery. CTI protocols are, at best, a useless exercise because outcomes were not considered and at worst, junk science that relies on other outdated studies rather than a realistic study of Ontario's accident victim outcomes.

7. The regulator should be provided with a sufficient budget to monitor and continuously improve the outcomes of existing programs of care and partner with the government on research into the development of new programs of care as the need arises – for example for neurological injuries, injuries from concussions, spinal cord injuries, chronic pain and post-traumatic stress disorder. Consideration should be given to leveraging existing programs of care that have been developed by other jurisdictions.

Insurers are involved in providing coverage or the means of financial support for recovery. They are not, nor should they be in the business of making healthcare decisions. They are profit driven and have no medical training and should not be relied on to make those choices. We don't buy a policy and ask is this insurer going to make good health related decisions on my behalf. We pay for insurance so that we will have the financial resources we need to pay for medical care that is recommended by medical professionals who are qualified. We should not be putting healthcare in the hands of profiteers and expect a good outcome. These are medical programs of care best left to the medical community and not insurers or their often irresponsible or partisan medical opinion vendors who are used as consultants on these projects.

8. The government should empower the regulator with the authority and direction to establish a roster of independent examination centres (IEC) which should be hospital-based and must be able to provide a multidisciplinary team to provide appropriate diagnoses of injured patients and recommended treatment plans. Insurers must follow, without dispute, the recommendations of the IEC for future treatment within the financial limits of the insurance policy as provided by law. The dispute resolution process must respect the evaluation of the IEC without resorting to competing opinions from either party to a dispute.

We feel that IMEs should not be hospital based. This would likely be too expensive and another way for insurers to download costs to taxpayers. IEC too closely resembles the current flawed WSIB model and simply takes the IME vendors to a new location with the same quality control issues.

Medical opinions and treatment recommendations at the initial part of the claim should be taken out of the hands of 'independent assessors' and put in the hands of publicly funded specialists through OHIP. In other words, follow the advice of patient's treating physician or treatment provider and their recommendations should be paramount. This

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goes to the concept of treating accident victims as the patients they truly are with an emphasis on the insurer obligation to provide treatment and recovery resources.

Insurers should make treatment dollars available to victims, payable directly to their providers and stay out of the diagnosis until such funding is exhausted. We are not recommending a particular amount of med/rehab dollars that should be available at this time as more research would have to be done. This also means that the MIG would be discontinued and IMEs would be eliminated at the beginning of the claim. This will increase profits for insurers while controlling negative and useless medical opinions from standing in the way of recovery for those individuals whose injuries are not catastrophic. Insurers will not direct treatments, MVA victims own health practitioners will make recommendations that insurers will pay for.

If and when the initial program of care (as recommended by patient's treatment provider) does not take the accident victim to maximum possible recovery, then a second stage of a claim would be implemented. It is at this level that limited IMEs would be necessary. The medical examiners could be chosen from a rostered list of accepted medical opinion vendors and insurers, who have a stake in the recovery of their client, could present a list of 3 to 5 appropriate assessors who are qualified to opine on the disputed treatment or the issues at hand and the claimant and/or their legal representative could agree on which assessor is appropriate to use. Insurers must make use of these experts in a responsible manner and with an eye toward facilitating recovery rather than facilitating their profits. Any expert that doesn't follow the program or rules or who demonstrates bias are removed from the roster. These medical opinions must have value and not continue to simply be a tool for denying claims. Many accident victims feel that they won't figure out what is wrong with them until after their claim is settled and this is unacceptable. Transforming the accident victim into a patient and treating them as any other individual in the system should overcome this obstacle.

9. The regulator should conduct regular quality control studies of the outcomes of future care recommended by IECs to monitor the quality of such recommendations and ensure their effectiveness. As part of this process the regulator should consider instituting a system of professional peer review of roster assessors to ensure quality is maintained.

Though we do not agree that the IEC model is workable, we do feel that monitoring outcomes for accident victims is a good idea. Right now, no one talks to victims, no one asks how their claim went or what improvements they might suggest. This is a big gap in information that can be corrected and provide valuable data. Peer review of rostered assessors may be necessary but all of these health professionals already have regulatory oversight, some better than others. We feel that intervention by the Minister of Health might be useful in putting pressure on regulatory Colleges such as CPSO whose members are often criticised in court hearings and whose lack of action to hold their member to account has made the situation for injured accident victims unbearable and unacceptable. The possibility of the Health Professions Appeal and Review Board (HPARB), who hears the appeals regarding the complaints at the various Colleges, should have their role expanded to enable them to take action when a College won't. We should not be tolerating doctors who harm in Ontario, it is unacceptable and it happens every day to both car accident victims and injured workers. The path may possibly be to simply make assessors owe accident victims, who are patients, the duty of care with the rights and regulation that every other patient in Ontario enjoys.

10. The regulator should undertake a complete overhaul of the pricing schedules for treatment by providers and evaluators to bring them more in line with prices being paid by other similar bodies, such as workers' compensation boards, and to emphasize outcomes rather than the number of treatments.

We agree that more importance needs to be attached to outcomes. It is the cost of the medical evaluator/assessor/expert opinion vendors that is out of balance and without regulation. Insurers are also paying outrageous cancellation fees to their preferred vendors that are far above what is paid anywhere else in any system. There is also an imbalance in that other treatment providers such as physiotherapists must register with FSCO but insurer doctors do not while it is these assessors who cause the harm while denying claims and it's where costs escalate.

11. There should be no cash settlements in the accident benefits portion of the Ontario auto insurance system for those benefits specified in the legislation as being for medical and rehabilitation care. Where the

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legislation provides for cash payments, for example for lost wages and lump-sum payments for catastrophically injured persons, these would, of course, continue to be paid.

A word of caution that not paying out/settling these SABS will lead to claimants having a lawyer on speed-dial for the rest of their lives, a life-time of battling with an insurer does not lead to a victim moving on - exactly the opposite. Even as we propose that the initial stage of the claim be processed as if the victim is a regular patient, we recognize that insurers at some point will want to have some control over how funds are spent. If med/rehab benefits are controlled by insurers indefinitely, it will lead to more disputes in the system. Once a victim's injuries and their needs are calculated, insurers should be encouraged to settle these claims as quickly as possible.

12. There is clear urgency to make the accident benefits system simple and accessible without the need for legal representation. Since accident victims are in a vulnerable position and contingency-fee arrangements are not very transparent, the government should consider:

- **Banning or restricting advertising and referral fees, and restricting contingency fees in personal injury cases, as the law society reports is being done in some jurisdictions such as in England, Wales and Australia.**

These calculations and decisions are best left up to the Law Society of Upper Canada to make.

- **Requiring contingency-fee arrangements to be filed with the regulator, who should inquire into their fairness on a spot-check basis and work with the relevant authorities to curtail abuses if they arise.**

Contingency fees should perhaps be reviewed or assessed for fairness after settlement and lawyers should have to keep dockets to prove they have performed the work - we are not against referral fees based on getting paid for actual work performed. Lawyers should have the option to pass on the file for many reasons but billing must match up to work performed. Perhaps a flat fee per hour that is used if a file travels from one lawyer to the next. Straight referrals without any work on file should have zero value. Again, these are issues best left to the Law Society of Upper Canada to decide.

We find that the blame for high costs of legal fees for claims is ill-placed to some degree. Insurers deny claims and MVA victims have little choice but to hire a lawyer at a time when they have few resources so contingency fees are working for them in respect to access to justice. Let's not forget who is running up the legal fees, it isn't victims, it is insurers, their adjusters, and their lawyers who start the cycle when they fail to adjust claims.

- **Settlement cheques should be made payable jointly to the accident victim and the lawyer. This will allow the accident victim to clearly understand the relationship between the total settlement and what he or she eventually receives.**

We agree with this simple step that ensures victims stay aware of what is happening in their file.

- **Claimants should be informed in writing, possibly on a final settlement schedule, of their right to appeal the fees charged by their lawyer, and where to apply to do so.**

There are significant issues with billing on an ongoing basis when it comes to victim's legal representation. We suggest that wording regarding the right to have a bill assessed be in bold print at the top of the billing and not in small print at the back of an invoice. We understand that there is a significant backlog at the Assessment Court and we would suggest that the Attorney General's office be consulted on how to improve the timeline for hearings.

13. The regulator should monitor the overall use of legal representation in the accident benefits system to analyze why claimants are needing to resort to legal advice. Also, the regulator should examine if the system should be further simplified, barriers should be removed or other practices changed to reduce the need for the time and expense of legal involvement.

FSCO, as regulator, has a slow response time, seems unwilling to take on insurers when it comes to consumer complaints while mirroring insurer language in the information they put out – disingenuous wording such as 'more choices' instead of 'cuts to coverage' misleads the consumer and doesn't give the accurate information consumers need. 2. The Insurance Act needs redoing and thresholds such as MIG and especially CAT should be removed

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because it leads to more adversarial positions. 50% WPI or 55% - the difference in coverage should not be over \$900,000.00 - this is leading to more disputes and those individuals whose injuries are very serious are without the support they need. Insurers behave as if big cheques are being written out to victims who are classified as CAT when the reality is that people don't get more than they need, in other words, just because a victim has \$1 million coverage for med/rehab doesn't mean that they will get \$1 million – they get what they need in an ideal world. The very seriously injured victim should not have to fight to get above the 55% whole person injury designation but they should get what they need. Insurers and victims are spending far too much to get past these arbitrary thresholds and too much court time and space is used to decide the threshold limits. Serious consideration should be given to eliminating these thresholds.

14. The regulator should monitor, on a continuous basis, the length of time insurance companies are taking to provide benefits to claimants and determine if undue delays are causing financial harm to accident victims.

All delays cause harm when one considers that most Canadians will run into financial difficulties in just 3 weeks if their income is disrupted. Insurers should be required to do their own file review by someone other than the working adjuster on the file when a file is open for more than 1 year. There should be a consumer Q+A office at the FSCO to answer routine questions such as how to fill out forms and this could include an office to handle consumer complaints about service/access to SABS and the regulator could require that a file be internally reviewed by the insurer to catch any adjuster errors. This all relies on consistent, across the board education of adjusters overseen by the regulator with a roadmap clearly defined to health and wellbeing. It will not be easy for insurers to shift gears though increased recoveries and less litigation should lead to higher profits in the long run.

15. Insurers should be required to establish an internal appeal process to provide an early resolution to claims and reduce the number that have to proceed to the external dispute resolution system. The regulator should monitor the effectiveness of the internal appeal process and be empowered to order corrective action if a particular insurer is generating an unusual number of claims to the dispute resolution process.

Monitoring insurer use of dispute resolution mechanisms would reveal if claims and adjusters should be reviewed as it could be an indicator of poor policy at a particular insurer.

16. The gatekeeper function at the Licence Appeal Tribunal should insist that a claim has gone through the insurer's internal appeal process before allowing it to proceed further. The gatekeeper should also determine that if new information is being introduced in the claim, it should go back to the original decision-maker to see if it changes the decision before the appeal proceeds.

Internal review process - see above comment #15 - could be utilized here as well. Shouldn't be labelled as insurer's 'internal appeal' but rather 'internal review' process.

17. In relation to medical condition and treatment, the opinion of the independent examination centre should be taken as definitive by arbitrators. If, in exceptional circumstances, the arbitrator has reason to be concerned about the independent examination centre opinion under consideration, the arbitrator can ask for a second opinion from a second independent examination centre from the regulator's roster. Competing examination opinions from experts hired by either the claimant or the insurer should not be permitted.

If we look back at the Designated Assessment Center (DAC) model the insurers were obligated to follow the recommendation of the DAC report. The decision of the DAC was often challenged at FSCO but the key was that insurers had to follow the opinion of the DAC assessors until such time as a hearing was held. All legal decisions should have the option to appeal, no system is infallible, no medical assessment perfect, and it is an accepted principal of fairness that the appeal is part of the justice system. Accident victims should have no less rights than any other ordinary citizen in Ontario and that includes the right to appeal. Concerns about assessors go to the rostering of these assessors and ultimately if the trier-of-fact has concerns about the independence of an assessor it should automatically trigger a complaint to their regulatory College.

We have serious concerns that this will take the form of WSIB roster where the same 'experts' are often performing poorly. This goes back to the patient rather than MVA victim - two very different positions to start recovery from. Imagine you had cancer and the OHIP system decided you weren't worthy of saving - not worth even trying - we

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wouldn't accept that and we shouldn't accept denying treatment for MVA victims. If this is going to be focused on recoveries - that's where the shift begins. Medical opinions accepted without challenge is a step too far - read the WSIB decisions and see how the doors to recovery assistance are slammed closed when 'opinions' accepted at face value. Rostering does not mean infallible and even the DAC decisions could be challenged though insurers were made to pay benefits until a hearing took place and had to follow the DAC assessment recommendations. Assessors do not even need to know who has requested the assessment if the roster route is implemented with FSCO or FSRA is in control, the request can come from the roster manager and who does the assessment can be agreed upon by plaintiff and insurer.

There are many options that control competing medical examination opinions including hot-tubbing where both plaintiff and defence must agree on an assessor and that eliminates competing opinions.

18. There is an urgent need to revise and simplify the legislation and current set of regulations and focus on desired outcomes and less on the details of process.

All stakeholders agree that the insurance Act is no longer workable and from a victims perspective it is less than understandable given how many tweaks and cuts and changes in the language that have taken place since No-Fault's inception over 25 years ago. With change came more confusion and that has worked only for insurers who can afford to pay their own legal representatives to find ways to deny claims. Clear precise language with meaningful sanctions for insurers who deviate from their contractual obligation to accident victims. The lack of sanctions, the disappearance of 'special awards' for victims who have been revictimized by their own insurer, the loss of PJI payable to victims when insurers wrongfully deny are at play here because the Insurance Act reflects the needs of insurers to realize more profit rather than to ensure that victims get what they need for recovery and reintegration into their lives.

19. The new regulator should be given authority to make regulations (already underway). Rules should support insurers to be in direct contact with their clients so that they can manage care and recovery for their clients.

Needs further definition - adjusters are not medical personnel. Insurers are in business to make money and know little about patient care. Care and recovery management for the 'patient' should be managed by the treating health practitioners and the patient as decision-makers and augmented by an independent case manager in more serious injury cases.

20. Consumer education in the field of auto insurance is a key component of a well-functioning system. In conjunction with making the rules and regulations governing the system simpler, the government should seriously address the need for enhanced consumer education. The recommendations of the Ontario Auto Insurance Anti-Fraud Task Force and the creation of an "Office of Driver Adviser" should be considered.

Insurers should have to participate by paying the cost of such an office and agree to present a more accurate picture of coverage to consumers. FSCO would have to take a more critical role here to serve the public's interest.

21. Repeal subsection 233 (2) and amend 233 (1) so that SABS claims and tort claims are subject to exactly the same rule that applies to other auto insurance claims. We would defer this to lawyers.

22. The government should consider implementing ways to make the system for automobile accident tort claims more streamlined, particularly:

- **Creating a prescribed list of documents that must be produced.** Yes, clear instructions would be helpful.
- **Allowing for earlier examination under oath for both claimants and expert witnesses.**

It's possible that this could cause duplication if a case doesn't get heard for a long time. Could be labelled as a case conference and scheduled after insurer file review process (1 year post accident) see #14.

- **Providing for some form of case management that encourages cases to proceed with a minimum of delay.** Yes

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23. The regulator should monitor the awards and costs of the tort system to determine if changes need to be made to the no-fault system to avoid having to sue under tort and to recommend changes to the tort system if costs appear to outweigh benefits from a public policy point of view.

Ontario should consider getting rid of the 'deductible' and if that's not palatable, then juries must be informed that this cost exists and what court and legal costs claimants have to pay. Not providing all information is unacceptable and the deductible is part of a problem of flawed legislation that violates the Charter in an obvious way. See #18

24. The independent examination centre's opinion as to the claimant's medical diagnosis and future care needs, should be given a zone of deference by the courts in tort cases. This means that the opinion of the independent examination centre should be taken as definitive unless there is compelling reason to doubt it.

No deference other than insurers must honour the opinion until the case reaches the courts if the IEC is implemented. Courts are not quality control, FSCO is and if FSCO doesn't want to be, then create a separate consumer protection unit. See #17

25. There should be full deductibility of accident benefits awards from tort awards.

A court tort award is sometimes not very detailed and where does the victim get the funds to pay for legal representation or to pay the unfair 'deductible'? While we agree there should not be double recovery, SABS should be a consideration, not a full deductible unless there is full transparency and calculation in respect to these other costs including the legal costs of holding an insurer to account. Insurers often renege on their contract through the course of a claim when it comes to income replacement, access to med/rehab/attendant care and sometimes positions change as do the needs of victims. If care not cash is to be implemented it has to be considered that a tort award which is final can't count on the changing whims of insurers when it comes to SABS. This is incompatible.

26. Contingency fees in tort cases should be made fully transparent to the client, including notification that fees can be appealed. Yes

27. Claimants should be informed in writing, possibly on a final settlement schedule, of their right to appeal the fees charged by their lawyer. Yes

28. Settlement cheques should be made payable jointly to the claimant and his or her lawyer to allow the claimant to fully understand and accept the disposition of the funds. Yes

29. To the extent possible, the regulatory regime should be overhauled to encourage insurers to innovate and introduce new products even on a trial or experimental basis.

Insurers have been saying for years that they are losing well over \$1 billion a year to fraud. Yet they are unable to account for the loss figure, nor have they been able to correct a problem they say exists. This is either incompetence or an inability to control their financial 'leakage'. Insurers consistently spend more on assessing injuries than treating victims. They've driven all of the changes to auto insurance and created the mess we are dealing with today. We fail to see what innovation they can offer when they clearly are unable to perform adequately to deliver prompt service to the clients they already have. Allowing insurers to 'experiment' means accident victims will be their guinea pigs and that's not what we should strive for.

30. The government should undertake a comprehensive review of auto insurance pricing alternatives with a view to providing more competition in the marketplace. Yes

31. A new, independent regulator with its own board of directors for automobile insurance be established either as part of the new Financial Services Regulatory Authority or a new separate office specifically for auto insurance.

We agree that the creation of the FSRA and a dedicated unit for auto insurance could lead to a more stable environment for consumers and insurers.

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32. The Insurance Act and regulations should be amended to include only broad principles and entitlements for benefits. The regulator should be responsible for interpreting the legislation and, following appropriate consultation with stakeholders, creating policies, guidelines and rules that are enforceable and not subject to challenge in the courts as long as they are in keeping with the letter and spirit of the legislation.

We believe that more detail would lead to less court challenges. Essentially the legislators don't fully understand auto insurance and insurers are quite happy to let claimants pay legal fees to have the terms or meaning of the legislation be defined by the courts the taxpayer pays for. Legislation should be more thoroughly reviewed, more details and parameters clearly marked so victims who can't afford it aren't forced to hire legal representatives. Other jurisdictions should be looked at with an eye toward more functioning systems without so many court cases and see what is working there. The Insurance Act should be simplified and MIG and CAT thresholds removed as a first step to lesser cases in our courts. Insurers need dis-incentives to deny legitimate claims through punitive measures that would apply across the board, honest mistake or not, wilful or incompetent, these mistakes are very costly for victims. While the term 'special award' deceptively implies that something out of the ordinary has occurred the reality is that without serious financial incentives to adhere to their promises of coverage, insurers will not just fall into line. There must be a real cost for bad behaviour.

33. The new regulator needs to be equipped with the staff and expertise to act as a central governor over the automobile insurance marketplace including the conduct of all the players and providers within that marketplace.

Auto insurance is a big and complicated file that deserves more focused attention.

34. The new regulator should be required to set standards of performance for the marketplace and to be accountable to the government for meeting those targets. Yes

35. Insurance companies must change their role from managing costs to delivering care to their customers. They will need to change their claims management and related practices in the process. They will also need to innovate and compete on service and cost.

Insurers must deliver on their promise of coverage and if they cannot, the Province must re-evaluate whether no-fault privately owned insurers is what we want and whether the download to the public taxpayer is greater than the benefit of these private for-profit insurance to citizens.

'FAIR – supporting auto accident victims through advocacy and education'

FAIR Association of Victims for Accident Insurance Reform

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