Ontario Auto Insurance System Reform

Review of Insurer-Independent Medical Examination Providers and Reform Options

Presented to: **Ministry of Finance, Province of Ontario**

Prepared by: Anthony Grande

Date: 2026-01-24
Location: Toronto, Ontario

This document reviews the current landscape of insurer-independent medical examination (IME) providers in Ontario's auto insurance system, analyses inefficiencies and costs, and proposes a lean, made-in-Ontario solution for dispute resolution and process improvement.

- Integrating a clinician-led assessment approach would reduce reliance on foreign owned third-party insurance examination companies while continuing to require regulated healthcare professionals to perform assessments, thereby removing intermediary administrative layers and lowering overall assessment costs.
- The quality and competence of Ontario healthcare professionals are already governed by rigorous college standards and continuous professional oversight. By contrast, many insurance examinations are conducted by professionals who do not provide rehabilitation services, with expertise defined within a financial services framework rather than through an integrated healthcare quality system.
- Redirecting assessment work away from foreign-owned intermediaries and toward Ontario-based regulated healthcare professionals would retain expertise and spending within the province while reducing unnecessary administrative duplication and is a win to Protect Ontario.

Table of Contents

Review of Insurer-Independent Medical Examination Providers and Reform Options in Ontario's Auto Insurance System

By Anthony Grande

Overview and Context

Ontario's auto insurance regime relies heavily on insurer-initiated medical examinations, often termed Independent Medical Examinations (IMEs) or Insurer Examinations (IEs), to evaluate injury claims. By law, claimants must attend these exams at the insurer's request. In practice, insurers contract private IME companies to arrange assessments by medical professionals ostensibly "independent" of the treating team. Over time, this IME system has grown into a parallel medical assessment industry, raising concerns about corporate ownership, data handling, costs, and redundancy with existing healthcare processes. Critics, including judges and regulators, have noted that many IME reports are biased or inaccurate, leading the Insurance Bureau of Canada to deem the IME system "broken" in Ontario. This briefing document analyzes the major IME providers in Ontario, their ownership and jurisdiction, and the implications for data governance and healthcare sovereignty. It then compares the IME system's function to established Canadian healthcare frameworks for second opinions. The analysis shows how the insurer-controlled IME model duplicates existing mechanisms, adding administrative overhead, eroding trust, and delaying care. Using LEAN principles, we identify non-value-added steps in the current process. Finally, we present the **"FAIR Care" model**, a proposed alternative using randomized, discipline-matched second and third opinions, and assess its expected behavioural, efficiency, and legal impacts. Potential counterarguments (consistency, oversight, cost control) are addressed, providing a comprehensive, evidence-based perspective for policymakers. All recommendations use Canadian spelling and a neutral tone, focusing on patient-centric and system-efficient solutions.

Major IME Providers in Ontario and Their Corporate Ownership

Several key companies dominate insurer-initiated medical examinations in Ontario's auto insurance sector. These IME vendors coordinate assessments on behalf of insurers and are pivotal in claims decisions. Below we identify the major IME providers, their corporate ownership structures, jurisdictions of incorporation, and any links to U.S.-based parent firms, as well as noting how these links may impact data governance and sovereignty.

ExamWorks (Direct IME and Affiliates)

ExamWorks is a U.S.-based multinational that has become a leading player in Ontario's IME market through acquisitions. In 2010, ExamWorks Group, Inc. (Delaware, USA) acquired Ontario's Direct IME partnership, establishing a Canadian subsidiary. The purchase agreement shows Direct IME Corp. (Ontario) as the purchaser and ExamWorks as the ultimate parent, illustrating the cross-border ownership. Since then, ExamWorks has expanded its Canadian footprint significantly, a Globe and Mail investigation noted ExamWorks "has seven subsidiaries in Canada" handling IMEs. These subsidiaries include assessment firms across multiple provinces (for example, ExamWorks acquired firms like Ducore Expertise and Cyclone Santé in Quebec). ExamWorks' Canadian operations are thus ultimately controlled by a U.S. corporation (and as of 2021, by U.S. private equity firm CVC Capital Partners).

Data Governance & Sovereignty: The U.S. ownership of ExamWorks' subsidiaries raises questions about data governance. Personal health information collected in Ontario IMEs may be accessible to a U.S. parent company, potentially subjecting it to U.S. laws (like the PATRIOT Act) that allow foreign authorities to access data. This cross-border control is a healthcare sovereignty concern, as Canadian claimants' medical records could be stored or processed on U.S. servers outside the full protection of Ontario's health privacy laws. Additionally, ExamWorks' business model centralizes administrative processing, administrators at these firms gather claimants' medical files, book assessments, and even *edit draft reports* before finalization. Such practices not only pose privacy questions but have led to integrity issues, with evidence that some IME companies altered medical professionals' opinions to favor insurers. This undermines trust in the independence of the assessment and suggests that the U.S.-style profit incentives of a multinational IME firm may conflict with unbiased medical reporting.

Cost Impact: ExamWorks' scale has not translated into lower costs for Ontario's system; on the contrary, its subsidiaries charge significant fees. A portion of IME expense goes to administration and profit: for example, about $2,000 per case is charged by IME firms on top of the physician's fee for activities like file handling and report preparation. These overhead costs ultimately fall on insurers (and thus premiums) or claimants. Judges have flagged some IME company fees as *"extravagant"*, citing one case where total assessment charges reached $38,000 for a single accident victim. In that instance, the largest bill came from an ExamWorks subsidiary (Cira; see below), including a single doctor's report billed at $4,800. Such figures indicate that IME vendors add a costly layer to the claims process, with funds going to third-party companies rather than to treatment.

Cira Health Solutions (SCM Insurance Services)

Cira Health Solutions (often referred to as Cira Medical Services) is a major Canadian IME provider used by auto insurers and others. Cira is part of SCM Insurance Services, a privately held Canadian insurance services conglomerate. While SCM is based in Canada, it has strong U.S. connections through ownership. In 2017, U.S. private equity firm Warburg Pincus made a majority investment in SCM Insurance Services to fuel its growth. This effectively put Cira

under U.S.-influenced ownership, even though Cira operates nationally in Canada. (More recently, SCM was acquired by U.K.-based firm Davies in 2023, further internationalizing its ownership). Cira touts itself as a "national provider of independent medical evaluations" with a large roster of physicians. Industry sources have described Cira as "an arm of Canada's largest privately owned assessment firm", underscoring its dominant domestic position.

Data Governance & Sovereignty: Being under a parent company with U.S. private equity control raises similar data governance concerns as ExamWorks. Sensitive health data handled by Cira could be subject to access or decisions by foreign investors whose priorities may not align with Canadian public interest. However, as Cira's data infrastructure and operations are primarily Canada-based under SCM, Canadian privacy laws (like PIPEDA and PHIPA) do apply on paper. The concern is whether U.S. stakeholders might influence data handling or compel data sharing. Moreover, healthcare sovereignty is at issue when Ontario's injury assessments rely on a company partially directed by U.S. capital. Key decisions, such as investment in technology, assessor training, or report policies, may be driven by corporate strategies set outside Canada. This could potentially put commercial interests ahead of local clinical and privacy standards.

Cost Impact: Cira's prominence also reflects in costs. As noted, it was involved in the costly assessment package totaling $38,000 for one claimant. The Globe and Mail's investigation found that Cira's assessments formed the largest portion of that bill. In general, large IME firms like Cira command substantial fees. Those fees are ultimately included in claim costs, which can boomerang as higher premiums or reduced benefits. Also, if a claimant succeeds in court, only a portion of excessive expert fees may be recoverable, leaving some injured victims or insurers eating the cost of these reports. Cira's example thus highlights how the current IME system's costs add friction, money spent on duelling assessments, rather than on therapeutic care.

AssessMed (Lifemark/Shoppers Drug Mart)

AssessMed is another significant IME provider in Ontario, distinguished by its ownership being entirely Canadian. AssessMed was acquired in 2019 by Lifemark Health Group, a national healthcare company. Lifemark itself was subsequently bought by Shoppers Drug Mart (Loblaw Companies) in 2022, meaning AssessMed is now under the umbrella of a major Canadian retail and healthcare corporation. Jurisdiction-wise, AssessMed is incorporated in Ontario and remains subject to Canadian governance. It operates Canada-wide, delivering independent medical evaluations for insurers, legal cases, and employers.

Data Governance & Sovereignty: Because AssessMed is Canadian-owned and operated, data residency and control issues are relatively straightforward. Claimant health information handled by AssessMed stays within Canadian jurisdiction, under Canadian privacy laws. There is no U.S. parent company, so concerns about foreign government access to data are minimal. Healthcare sovereignty concerns are also alleviated, decision-making lies with a Canadian company whose incentives align with domestic healthcare networks (especially now integrated with Shoppers/Loblaw, which has a stake in community health services). This means Ontario's regulators have clearer oversight and Canadians have more transparency on corporate practices (Loblaw is publicly listed in Canada, with associated disclosure obligations).

Cost Impact: Being part of a healthcare group, AssessMed might leverage synergies (for example, Lifemark's network of clinics and practitioners) to potentially contain costs. However, like other IME firms, it charges insurers for coordination and reports as a for-profit service. The exact fee structure is proprietary, but the general industry pattern of admin overhead likely applies. One possible benefit of AssessMed's structure is that it is part of a broader treatment provider organization (Lifemark), so it may have more familiarity with actual rehabilitation processes. Even so, from a system perspective, AssessMed still represents an extra cost layer similar to other IME companies, its assessments do not come cheap, and the expense adds to the claims costs indirectly borne by policyholders or claimants.

Other Notable IME Firms (Sibley, Genex, etc.)

Beyond the top three, a variety of other companies conduct insurer examinations in Ontario:

- **Sibley & Associates** – An Ontario-based assessment firm that has long served insurers, especially for complex or catastrophic injury files. Sibley is known within the industry but has faced controversy. Investigations revealed that Sibley administrators at times interfered with medical teams' reports – for example, instructing assessors to *"remove sections or water down certain opinions"* unfavorable to an insurer's case. This suggests that even Canadian-run IME firms were subject to biasing pressures. (It is unclear if Sibley remains independent or was acquired by a larger entity; some IME conglomerates absorbed smaller players in the 2010s, but public documentation is limited. For context, Sibley was mentioned separately from ExamWorks in media reports, implying it was not owned by ExamWorks at least at that time.)
- **Genex** – Genex is a U.S.-headquartered disability and case management company that occasionally appears in Ontario auto insurance cases. In one high-profile claim, *TD Insurance contracted Genex* to coordinate an assessment, and Genex in turn engaged a local physician. Genex's involvement underscores that U.S.-based firms sometimes directly handle Ontario files, likely for insurers that have cross-border vendor relationships. As a U.S. company, Genex brings the same data sovereignty concerns as ExamWorks, any data transmitted to Genex could be subject to U.S. jurisdiction. Genex's core business is in workers' compensation and disability management, but its role in the auto claim illustrates the interconnected nature of assessment services.
- **Viewpoint Medical Assessment**, **SOMA Medical Assessments**, **CBI Health (Assessment Services)**, **ARS Assessments**, and others – These are Canadian outfits offering independent assessments or file reviews. Some are regional or niche (e.g., focusing on functional capacity evaluations or psychological IMEs). CBI Health's Assessment Services division, for instance, can provide IMEs or peer reviews, and CBI is a Canadian company (with significant investment from private equity, including U.S.-based investors in the past). These smaller or specialized firms collectively handle a share of insurer exams, though the bulk of volume tends to go to the larger networks described earlier.

In summary, Ontario's IME landscape is a mix of domestic and foreign-owned companies, with a notable trend of consolidation by large multinationals (ExamWorks, SCM/Davies) in the past decade. This consolidation has created very large vendors capable of servicing insurers nationwide, but often with U.S. parentage or capital. The corporate structures influence everything from how data is stored to how profits flow (often out of Canada in the case of U.S. parents), and they introduce an external corporate layer into what is fundamentally a healthcare determination process.

Data Governance, Privacy, and Healthcare Sovereignty Implications

The integration of U.S.-linked corporations into Ontario's auto insurance medical exam system has raised significant data governance and healthcare sovereignty issues:

- Cross-Border Data Access: When IME providers are owned or controlled by U.S. entities, Canadian claimants' medical information may be accessed or stored outside Canada. Under U.S. law, companies (or their subsidiaries) may be compelled to disclose data to American authorities, potentially without the knowledge or consent of the individuals, under statutes like the USA PATRIOT Act. This is problematic because Ontario accident victims, by virtue of filing an insurance claim, could have their private health records flow to a foreign jurisdiction that does not provide the same privacy guarantees. Even if the data physically remains on Canadian servers, U.S. parent companies could access it remotely. Canada's federal privacy commissioner has noted that cross-border data flows mean Canadian data can become subject to foreign laws once it's accessible by a foreign parent. Thus, policyholders might unknowingly sacrifice some privacy protections when their insurer uses an IME vendor with a U.S. parent.
- Jurisdiction and Accountability: Healthcare sovereignty refers to a jurisdiction's control over its healthcare practices and data. In Ontario's public healthcare (OHIP) system, patient data stays within Canadian-regulated entities (hospitals, clinics) with accountability to Canadian law. By contrast, the auto insurance IME system operates quasi-outside the public system, and when providers are foreign owned, it creates a grey zone of accountability. Ontario regulators (like FSRA or the Information and Privacy Commissioner) may have limited reach over a Delaware or Georgia-based parent firm. If an IME company's data practices were questioned, the investigation could be complicated by multinational corporate layers. Moreover, decisions about IME processes (e.g. how reports are handled, retention policies for records) might be driven by corporate boards in the U.S. who are not directly answerable to Ontario authorities or consumers.
- Alignment with Canadian Health Ethics: Canadian healthcare is founded on principles of patient privacy, consent, and trust. There is a concern that for-profit IME vendors, especially those influenced by U.S. insurance industry norms, prioritize insurer interests over patient rights. For example, the revelation that some IME companies *ghost-wrote or altered medical opinions* in reports to favor insurers is a serious breach of medical impartiality. Such practices violate the ethical expectations in Canadian medicine. When these companies are effectively agents of insurers rather than neutral

parties, it challenges the sovereignty of medical decision-making – i.e., medical judgments are swayed by external corporate interests. The Canadian Medical Protective Association and regulatory colleges have expressed disapproval of any such bias in independent examinations, but enforcement is difficult when the corporate culture might implicitly encourage reports that help reduce claims. In essence, outsourcing medical evaluations to foreign-controlled firms can erode the independence of medical opinions, which traditionally are protected within Canadian self-regulated professions.

- Data Security and Patient Consent: Claimants often have little choice but to sign broad consent forms allowing IME vendors to collect and share their health information. With multiple hands (insurer, IME company, sub-contracted assessors) on the data, the **risk of breaches increases**. A U.S. parent might further share data within its conglomerate (ExamWorks, for instance, operates in multiple countries and in related lines like record retrieval and bill review). Each handoff is a potential weak link. From a sovereignty perspective, Ontario would ideally want sensitive health data kept to need-to-know Canadian entities. Currently, that ideal is compromised whenever an insurer's vendor is not fully Canadian-controlled.

In summary, foreign ownership of IME providers introduces privacy vulnerabilities and dilutes local control over how medical assessments are conducted. It underscores the need for robust agreements and perhaps regulation to ensure that any data leaving the public health sphere remains protected. Policymakers might consider requiring that insurer assessments be stored and processed on Canadian soil and that IME firms adhere to Ontario's health privacy standards (PHIPA) even if parent companies are foreign. Healthcare sovereignty is better preserved when medical judgment and data stay within the Canadian context, aligned with our healthcare values and privacy expectations. The current model, as it stands, has drifted from that ideal.

Redundancy of IME System vs. Existing Healthcare Frameworks

Ontario's insurer-driven examination system often duplicates functions that already exist within regulated healthcare frameworks. In Canada's healthcare and disability management systems, whether in hospitals, or professional regulatory bodies, mechanisms for second opinions and oversight have long been in place. This section compares the IME model to those established frameworks and illustrates how the insurer-controlled process is largely redundant, adding complexity rather than value.

Second Opinions and Peer Review in Healthcare

In standard healthcare practice, when there is uncertainty about a diagnosis or treatment plan, second opinions are easily obtained within the system. For example, a family physician can refer a patient to a specialist for another evaluation, or a surgeon might seek a colleague's review before a high-risk operation. Hospitals foster an environment of multidisciplinary case conferences and peer consultations, especially for complex cases, effectively an internal IME by another name. These processes are clinically driven and patient centred. They do not require an

external company to mediate; rather, they rely on professional collaboration and judgement. The goal is to ensure optimal care, not to approve or deny coverage.

Importantly, no separate "for hire contract insurance doctor" approval step exists in public healthcare. If treatment is medically necessary, OHIP covers it based on the treating physician's orders (subject to clinical guidelines). There isn't an adjuster sending a patient to an external physician to verify need before treatment is authorized, that concept is foreign to our public system. This is echoed in the auto insurance context by the observation that *requiring an insurance-paid second opinion to proceed with treatment "does not occur in OHIP"* (Ontario's health plan). In other words, **Ontario's own health ministry trusts the treating professionals**, guided by college standards, to make appropriate care decisions without interjecting third-party examiners.

WSIB's Approach to Independent Assessments

The **Workplace Safety and Insurance Board (WSIB)**, which handles work injury claims in Ontario, provides a useful comparative model. WSIB manages injury rehabilitation and benefits for workers through a system that balances compensation with return-to-work goals. While WSIB does have mechanisms for independent assessments, they are handled quite differently from auto insurance IMEs:

- **Reliance on Regulated Clinicians:** WSIB generally accepts treatment recommendations from the worker's healthcare providers, who are all regulated professionals. WSIB does not require those providers to hold a special license beyond their college certification. In fact, under WSIB, *healthcare providers are solely regulated by their professional colleges, which have proven effective in maintaining high standards of care*. This implies trust in the existing regulatory framework without layering an external IME industry on top.
- **No IME for Treatment Plan Approval:** Critically, WSIB does not mandate an "independent" medical exam to approve each treatment plan the way auto insurers often do. A treating physiotherapist's plan for a worker can typically proceed without a stranger second-guessing it upfront. This was highlighted in FSRA's consultation feedback: *"an insurance 'opinion' to approve treatment recommendations does not occur in WSIB or private practice"*. The inference is that auto insurers' routine use of IMEs is an outlier. WSIB demonstrates that a system can function, and even control costs, by utilizing internal expertise and guidelines instead of defaulting to external exams.
- **Appeals and Medical Panels:** If a worker disagrees with WSIB's decision or WSIB doubts the treating physician, the dispute can go through the WSIB appeals process or the Workplace Safety and Insurance Appeals Tribunal (WSIAT). In such cases, independent medical experts might be called, but again they are usually engaged as neutral experts under the tribunal's authority, not hired guns of one party. This is more analogous to how courts use independent experts. The key is **neutral selection** and a formal process, rather than one side unilaterally sending the claimant for an exam.

Role of Self-Regulated Colleges and Peer Oversight

Ontario's health professions are **self-regulated** by colleges (e.g., College of Physicians and Surgeons of Ontario, College of Physiotherapists of Ontario). These colleges enforce standards of practice and ethics. They also have quality assurance programs, which may include **peer reviews and audits** of practitioners' work. For example, the College of Physicians can randomly select a physician's practice for a peer assessment or investigate if concerns arise about their clinical decisions (including any improper assessments). Similarly, if an insurer or patient believes a treating therapist's plan is inappropriate, they can lodge a complaint with the therapist's college, prompting a professional review.

The existence of these regulatory mechanisms means that Ontario already has a built-in system of checks and balances on healthcare decisions. If a provider is over-treating or misdiagnosing, their professional peers can sanction or retrain them. This is a critical point: the IME system duplicates oversight that colleges are designed to handle. Rather than trust the colleges, insurers superimposed their own process.

In practice, however, colleges seldom get involved at the speed of an insurance claim dispute, their processes are disciplinary and can be slow. Insurers felt a need for immediate second opinions for claim control. But it's worth noting that within hospital settings, peer review for complex cases happens in real-time (e.g., grand rounds or tumor boards for cancer care). Ontario's healthcare framework encourages second opinions through referrals, not through adversarial exams. The IME model essentially *privatized* the second-opinion process, taking it away from the collaborative healthcare context and placing it in an insurance context.

Duplication and Administrative Overhead

Because the IME system runs in parallel to the healthcare system, it duplicates many functions and introduces significant administrative overhead:

- Duplicate Assessments: When an insurer sends a patient for an IME, that patient has often already been assessed by one or more qualified healthcare professionals (family doctor, specialist, physiotherapist, etc.). The IME doctor frequently repeats the basic history-taking, physical examination, and record review that have already been done. This is duplication of effort. No new treatment is provided, it is purely an evaluative exercise, often covering ground already in the medical file. In Lean terms, this is *over-processing*: performing more assessments than necessary to get the needed information.
- Extra Documentation and Communication: In a normal course, a treating clinician would document findings and perhaps communicate with an insurer if needed. Under the IME model, there is a whole extra layer of paperwork, referral forms to the IME vendor, transfer of voluminous files, the IME report generation, and then the insurer's internal review of that report. These steps are non-value-added from a patient's perspective; they serve a bureaucratic purpose. They also cost money: as noted, IME companies charge around $2,000 in admin fees per case for these coordination activities,

which is pure overhead. Those costs don't exist in WSIB or OHIP contexts where no third-party coordinator is needed.

- Delay in Care: Perhaps the most damaging duplication effect is delay. When an insurer disputes a proposed treatment and orders an IME, the treatment often halts until the IME report is in (and often, any subsequent dispute resolution is finished). This can introduce weeks or months of delay. For example, if a physiotherapist prescribes further rehabilitation and the insurer sends the patient to an orthopedist for an IME, by the time that appointment is scheduled, completed, and the report returned, the injured person has gone without the recommended therapy, sometimes exacerbating their condition. Real-world cases illustrate this: one accident victim, Mr. Blais, had his therapy cut off and spent *six years* fighting the insurer with the help of IME reports, during which his condition worsened, and he ultimately lost his livelihood and home. Such delays undermine recovery and erode trust. In hospital settings, by contrast, when a second opinion is sought, it is usually concurrent with care (or obtained as quickly as possible) to avoid delaying necessary treatment. The IME model's adversarial nature inherently injects *waiting time*, a form of waste in Lean analysis, into the care pathway.
- Cost Without Benefit to Health: The money spent on IMEs yields no direct health benefit. It's essentially an expenditure to verify or dispute claims. From a system efficiency standpoint, this is questionable when Ontario could instead channel resources to actual treatment or injury prevention. The Globe and Mail's analysis found that doctors performing IMEs in auto insurance earned about $240 million a year from these assessments in Ontario and B.C. combined, and that these reports were primarily used by insurers to limit payouts rather than to enhance care. That staggering sum, nearly a quarter of a billion dollars annually, is diverted from therapeutic services to paper reviews and exams whose outcome often confirms what treating practitioners already knew. In other words, the IME apparatus functions as a parallel medical bureaucracy, one that the public health or workers' compensation systems do not require to nearly the same extent.
- Erosion of Trust and Therapeutic Relationship: In healthcare, trust between patient and provider is paramount. The IME system inherently creates mistrust, the patient knows the IME doctor is paid by the insurer and not there to treat them, leading to guarded interactions. Likewise, treating providers may feel undermined when their clinical judgment is second-guessed by a doctor who sees the patient once. This can create adversarial dynamics between providers and insurers. By contrast, WSIB, for all its shortcomings, often engages treating practitioners as partners in return-to-work planning rather than immediately assuming adversarial positions. The duplication of opinions via IMEs can also cause confusion: patients get conflicting medical opinions and may not know whom to believe. This contrasts with a referral-based second opinion, where the two doctors might actually discuss the case and come to a consensus. In the IME scenario, consensus is rare, it's more often a battle of reports if it goes to a legal dispute.

In sum, Ontario's IME system mirrors functions that our healthcare system and other insurance systems (like WSIB) already fulfill, but with added cost and conflict. It requires extra licensing (FSRA's Health Service Provider licensing) and compliance that *"frameworks like OHIP or WSIB"* do not impose, thereby piling on red tape without clear benefit. As one submission to

FSRA noted, this duplication of oversight and process ultimately "drives up prices in the auto insurance sector" for consumers. The next section will explicitly analyze these redundant steps through a Lean process improvement lens, identifying where non-value-adding activities occur in the insurer IME model.

LEAN Analysis: Redundant and Non–Value-Adding Steps in the IME Process

Applying LEAN principles (which focus on maximizing value and eliminating waste) to the insurer-controlled examination system reveals multiple inefficiencies and steps that do not add value to patient care. Below are key IME process elements viewed through a Lean "waste" lens, compared with how a streamlined approach could improve them:

- **Overprocessing (Duplicate Assessments):** The IME involves a new practitioner re-doing much of the work (history, exam, file review) already performed by the treating team. This repetition is classic overprocessing waste. It does not improve the patient's health outcome, it merely produces a report for the insurer. In Lean terms, any step that doesn't directly benefit the end-user (the patient) is suspect. Here, the patient gains no additional treatment or insight from the second examination (indeed, many IMEs are "paper reviews" where the doctor never even sees the patient). The value of medical evaluation was largely captured in the first assessment; doing it again adds cost and time, not value.
- **Transportation and Motion:** Lean identifies unnecessary transport or movement as waste. Under the IME system, injured individuals often must travel to attend assessments, sometimes long distances if a specialist is in another city. This is transportation waste imposed on the patient. There is also "motion" waste in the administrative sense: multiple hand-offs of information (insurer to IME company, IME co to doctor, doctor back to IME co for editing, then to insurer). Each hand-off is an opportunity for error and delay. In a streamlined system, one would aim to minimize how far information and people have to travel.
- **Waiting (Delays):** The period during which a claim is put on hold awaiting an IME outcome is pure waiting waste. The patient waits for needed treatment authorization, the providers wait for payment or direction, and even the insurer's decision-making is paused. This can be significant, weeks to months of waiting. Lean strives to eliminate wait times by synchronizing processes. The current model does the opposite: it inserts an intentional wait (for the IME scheduling and report) into what could be a continuous care flow. The result is not only wasted time but potentially deterioration in health (which can create additional costs, as injuries worsen or chronic pain sets in during the delay).
- **Inventory (Backlog of Disputes):** In claims handling, unresolved disputes are akin to excess inventory. Ontario's License Appeal Tribunal (LAT) has a large backlog of cases, many involving duelling medical opinions. Each case is an "inventory" of unresolved issues being carried. This stems from the IME system because every time an IME contradicts a treating provider, a dispute is born that may sit in the system for months or years (the LAT can take years to resolve disputes). Lean thinking would push

to resolve issues as they arise rather than let them back up. The IME process, however, often escalates to litigation (inventory of cases) instead of prompt resolution, partly due to its adversarial nature.

- Defects and Rework: A "defect" in Lean is an output that is incorrect or substandard, requiring rework. IME reports have frequently been found to contain errors or biased conclusions, essentially *defective outputs* from the process. Judges and arbitrators have rejected numerous IME reports for being fundamentally flawed or not credible. Each time this happens, it's akin to a defective part in a factory that must be redone or scrapped. The cost of these defects is high: the insurer paid for the report, and now must perhaps pay for another, or for a treating doctor's rebuttal, or in the worst case, lose a legal case because the evidence was not accepted. A Globe and Mail investigation uncovered cases where IME companies *edited reports in the insurer's favour or ghost-wrote portions*, which is a serious defect in process integrity. The rework might involve further assessments or legal remediation. In a more value-driven system, one would aim to "do it right the first time," relying on unbiased expert opinion initially rather than having competing reports and corrections.
- Non-utilization of Talent: One of the wastes sometimes identified in Lean for service industries is not using people's full talents. In the IME scenario, consider that treating healthcare providers (who know the patient best) are often sidelined or discounted, while an outside assessor's opinion is given more weight by insurers. The treating professionals' expertise and relationship with the patient are underutilized, instead, a one-time examiner's view prevails. This is arguably a misallocation of medical talent. A more integrated approach might involve engaging treating providers in a dialogue or case conference if an insurer has concerns, tapping into their insight rather than disregarding it. Currently, the system largely ignores the treating clinician once an IME is involved (except insofar as their notes become fodder for the IME's report).
- Redundant Administrative Systems: Ontario's auto insurance has built parallel administrative systems (HCAI for billing, FSRA licensing for clinics, etc.) in an attempt to manage and monitor providers, largely because insurers felt they needed extra control. Many of these systems duplicate what already exists in healthcare or other insurance domains. For instance, FSRA's health provider licensing was an extra layer "not required under frameworks like OHIP or WSIB", and it resulted in *"excessive administrative burdens" with costs passed to consumers*. The IME system is part of this redundancy. It is effectively an external utilization review and claims adjudication system running in parallel to the actual care delivery. Lean analysis would ask if this parallel structure added value commensurate with its cost. Given that OHIP and WSIB manage without such an elaborate external exam regime, it suggests the answer is no, the added layer is wasteful.

By mapping out these inefficiencies, it becomes clear that the insurer-driven IME process is rife with Lean "wastes", overprocessing, waiting, transport, defects, etc. It creates redundant steps that do not improve the end outcome (patient recovery). As one submission aptly put it, *"stop trying to reinvent the wheel and use what works well in other frameworks"*. In other words, instead of this convoluted process, Ontario could lean on the existing healthcare second-opinion

systems that are simpler and less wasteful. In the next section, we explore one such Lean-inspired alternative: the FAIR Care model, which seeks to remove these inefficiencies and restore trust and value.

The FAIR Care Model: A Lean, Fair Alternative for Medical Dispute Resolution

As a response to the challenges outlined, stakeholders have proposed a new model for managing treatment disputes in auto insurance: the FAIR Care model (Fair Auto Insurance Reforms model, also implying a focus on fairness in care). This system-design alternative aims to use existing self-regulatory and clinical frameworks to provide truly independent second (and third) opinions, eliminating the current biases and inefficiencies. The hallmark of FAIR Care is *randomization* and *clinical discipline matching* in selecting reviewers, thereby removing any party's control over who evaluates the case. Below, we detail how the FAIR Care model works and why it addresses the concerns of bias, redundancy, and delay.

Key Features of the FAIR Care Model

1. *Randomized Selection of Reviewer:* When an insurer disagrees with a proposed treatment plan, instead of choosing an IME doctor or company, the case is referred to a randomly selected healthcare provider or clinic for a second opinion. Neither the insurer, the claimant, nor their lawyers have any influence over this selection, it could be *any* qualified clinic from an approved roster. This is crucial: random allocation prevents "doctor shopping" and any perception of bias or coziness. It mirrors how some court systems assign neutral experts or how workers' comp boards might rotate referrals. Randomization ensures no financial relationship can develop where one side's referrals consistently go to the same assessor. Every case is essentially a lottery, making the outcomes harder to game.
2. *Discipline-Matched Second Opinions:* The model requires that the professional discipline of the reviewer matches that of the treating provider who originated the plan. For example, if the disputed treatment plan is written by a physiotherapist, then the second-opinion assessor will be a physiotherapist (not a physician). If it's a surgical recommendation by an orthopedic surgeon, another independent orthopedic surgeon reviews it. This ensures the reviewer has the appropriate expertise and context. It also resonates with fairness, peers reviewing peers. Notably, this approach hearkens back to prior practice: professional associations in Ontario had long advocated for same-profession reviews, and this was common in older dispute schemes (before around 2010). Enforcing discipline matching means the opinions are clinically relevant and credible, avoiding scenarios we see today (e.g., a physician with no physiotherapy experience critiquing a physio's rehab plan).
3. *Structured Second and Third Opinion Process:* Under FAIR Care, the dispute can go through up to three rounds:
    - **Second Opinion:** The randomly chosen clinic/professional conducts an independent review of the treatment plan (this is an in-person assessment of the claimant). They then provide their opinion on the plan's necessity and

appropriateness. If this second opinion agrees with the original treatment plan, the insurer would be expected to approve treatment (since an impartial peer confirmed it). If it sides with the insurer (i.e., finds the treatment excessive or unrelated to the accident), then the claimant can request a further review.
    - **Third Opinion (Tiebreaker):** In cases of continued disagreement after the second opinion, a third review is triggered, again by a randomly selected professional of the same discipline. This acts as a final arbiter.
    - **Majority Rule Outcome:** The final decision follows a "two-out-of-three" rule. Whichever position (pro-treatment or against) is supported by two out of the three independent assessments becomes binding. This majority approach statistically reduces the impact of any one outlier opinion and gives confidence that the outcome is the consensus of multiple experts rather than an idiosyncratic view.
4. *Integration with Existing Regulatory Framework:* The FAIR Care model leverages the fact that all the clinicians involved (treating and reviewing) are already licensed and regulated by their colleges. There is no new regulatory body needed; the process would utilize rosters of willing clinics that meet certain criteria (e.g., being in good standing with their college, experience in auto injury care, etc.). Because these reviews are done by practicing professionals, the model leans on clinical standards of practice. The focus of the review is strictly clinical: e.g., *Does the patient have ongoing impairments from the accident? Is the proposed treatment reasonable and necessary?*. These are determinations within the competency of healthcare professionals. By removing "hired gun" IME vendors and replacing them with neutral peers, the model expects higher fidelity to medical ethics and evidence-based care standards.
5. *Transparency and Simplicity:* All parties would understand the rules upfront, a treatment plan may be randomly reviewed, and the outcome will depend on a majority of opinions. There is no opaque backroom editing of reports as was found with some IME companies; each reviewer independently documents their view. The random assignment could be overseen by a centralized system (possibly administered a neutral third party like a professional healthcare regulator) to ensure integrity. The process is relatively quick: because it's meant to *replace* litigation or lengthy insurer investigations, timelines would be tight (perhaps the second opinion must occur within, say, 2-3 weeks of the request, and a third opinion (if needed) shortly after). This way, disputes are resolved in a matter of weeks, not months or years.
6. *Cost Structure:* The insurer pays for these reviews, just as they pay for IMEs now, but the cost is likely lower. Each reviewing clinician would be paid a professional fee (perhaps standardized or capped by FSRA to prevent excessive billing). There is no need to pay a middleman company a large markup; the infrastructure could be minimal (maybe a web portal for assigning cases randomly). This means the overall cost per dispute should decrease relative to the current IME approach, where a single IME can cost thousands and multiple IMEs plus legal fees in a drawn-out fight can cost tens of thousands. Moreover, faster resolution saves money in claim handling overhead for insurers and gets claimants treated sooner (which can reduce total medical costs by avoiding complications).

How FAIR Care Eliminates Waste and Bias (LEAN Benefits)

The FAIR Care model directly addresses the wastes identified in the current system:

- Eliminating Duplication: Instead of an adjuster automatically ordering a new in-depth assessment, the first step is a review of the treatment plan by a peer. The two or three opinions rule bounds the process, preventing iterative IMEs. Once a majority consensus is reached, the dispute is done, no further "opinion shopping." This drastically cuts down the duplication. Also, by matching disciplines, it avoids scenarios where multiple specialists weigh in unnecessarily; it stays focused.
- Reducing Waiting and Delays: A randomized assignment system could be automated and quick. Many clinics would likely volunteer to be on the roster (since they are paid for reviews), meaning province-wide availability. The timeline from dispute to final decision could be measured in days or weeks. By contrast, current IMEs often involve waiting for the next available slot of a particular doctor favored by the insurer, which can be many weeks. And if it goes to litigation, the wait is years. FAIR Care's streamlined, immediate second opinion means the patient isn't left in limbo for long. In Lean terms, it dramatically shortens the value stream from dispute to resolution, attacking the waiting waste. One submission asserts that this approach would *"expedite patient care and reduce unnecessary legal costs"*, precisely by resolving disagreements faster and more impartially.
- Minimizing Transportation/Motion Waste: The random selection could prioritize a **clinic geographically close** to the patient (since there's a large pool). This is a patient-centred improvement. No more driving to an insurer's chosen IME doctor across town or in another city simply because that doctor is known to provide insurer-favourable opinions. Instead, convenience and efficiency can be factors in assignment (without compromising randomness, for example, the pool can be filtered for region and discipline, then randomize). Also, because the process is contained within the healthcare provider community, medical information flows directly to peers, not through multiple administrative layers. The treating clinic sends the treatment plan (likely via a secure system) to the reviewing clinic. It's a one-step transfer, not a multi-step relay through IME company coordinators.
- Preventing Defects (Biased Reports): By removing the incentive structures that lead to biased reports, the quality of assessments should improve. In the FAIR model, reviewers have no stake in the outcome, they get paid the same regardless of whether they agree or disagree with the treatment. They cannot be chosen for being "pro-insurer" or "pro-claimant" because selection is random. Therefore, one would expect the content of their reports to be more balanced and clinically justified. In addition, because two independent opinions must align to overrule the other, an outlier or low-quality opinion can be outweighed by the other experts. This reduces the impact of any "defective" assessment. Over time, if a particular provider's reviews are consistently at odds with peers or seen as subpar, the organizing body could drop them from the roster (introducing accountability). Contrast this with now: insurers often repeatedly hire certain examiners

known for conservative opinions, effectively *rewarding* bias. FAIR Care *discourages biased assessments* by design, as noted: *"the party ordering the dispute is not as certain of the result"*, which in itself will "significantly reduce…disputes" (since adjusters know they cannot guarantee a favorable outcome).

- Streamlined Process (No Middlemen): The process aligns with LEAN's principle of cutting out intermediaries that don't add value. It uses existing clinics, essentially moving the review to the point of care, broadly speaking, rather than using separate IME firms. This avoids the extensive admin fees paid to IME vendors and leverages infrastructure already in place (clinic offices, practitioners). A comment from the consultation encapsulates this: *"not reinventing the wheel"* but using what we have. The value added is purely in the clinical review and decision, nothing more. By focusing on that, FAIR Care aligns resources toward resolving the question "Is this treatment reasonable?" and nothing else.

Lean methodology often asks: *what would the ideal process look like if we started fresh, and how far can we move toward that?* The FAIR Care model is essentially a reimagining of dispute resolution from scratch, prioritizing fairness, speed, and clinical integrity. It creates a self-regulating ecosystem where health professionals essentially police each other's recommendations in a structured way, rather than involving external non-clinical entities. This leverages the fact that the vast majority of healthcare providers aim to practice ethically; peer review can correct the rare outliers (whether someone is over-treating or an insurer is over-skeptical).

Expected Behavioural Impacts

If implemented, the FAIR Care model would likely change the behaviour of several stakeholders in beneficial ways:

- Insurance Adjusters: Under the current system, adjusters hold significant power by virtue of selecting who will assess a claimant (often choosing assessors with a track record of siding with insurers). In the new model, this power is removed. *"Neutralizing the power imbalance"* is a key effect. Adjusters, knowing they cannot hand-pick an assessor, will be more judicious in challenging treatment plans. They are less likely to request a review for frivolous or marginal reasons because a random peer might very well agree with the treating therapist, which would quickly validate the treatment and obligate the insurer to cover it. Thus, adjusters would reserve disputes for cases where they genuinely believe there's over-treatment or a non-accident-related issue. This fosters a more cooperative dynamic rather than a default adversarial stance. Moreover, with transparent outcomes, adjusters gain clarity, if two out of three professionals say the treatment is needed, it probably is. This could shift adjusters' focus towards facilitating appropriate care (since the fastest way to close the file is to get the person better, rather than to fight the claim). In short, insurers' behaviour would shift from relying on hired opinions to accepting neutral outcomes, encouraging them to authorize reasonable treatments sooner.

- Healthcare Providers (Clinics/Therapists/Doctors): For treating providers, the FAIR model is empowering. They know that if their plan is sound, an impartial peer in the same field is likely to concur. It removes the frustration of having their clinical judgment trumped by someone in a different discipline or by an assessor perceived as biased. That said, it also holds providers accountable, if a treatment plan is truly excessive or not evidence-based, their peers will call it out. This peer accountability can improve overall quality: providers have incentive to ensure their plans are solid and well-documented, knowing a colleague might review them. This self-regulation is more aligned with professional ethics than insurer intervention. As the consultation document noted, it "creates a self-regulating ecosystem that encourages fairness and professional accountability". The relationship between clinics and adjusters could also normalize, with fewer external IMEs, providers can communicate more directly with insurers (through treatment updates, etc.), and disagreements get resolved through this structured peer process rather than letter-writing wars or litigation. Trust may gradually be restored as providers see that insurers will abide by neutral decisions, and insurers see that most providers are not over-treating when an unbiased third-party review it.
- Claimants (Patients): For injured individuals, the process becomes far less intimidating and more transparent. Instead of fearing the "IME doctor" who might not listen or might misrepresent their condition, they can have more confidence that any review is meant to be fair. Knowing that a third opinion is available if there's disagreement also reassures claimants that one nay-sayer won't seal their fate unjustly. Psychologically, this is important, many claimants currently report feeling that IMEs are a tool to cut them off benefits, not a genuine attempt to evaluate them. Under FAIR Care, because the reviewers are randomly assigned and presumably neutral, claimants might be more accepting of outcomes. If two out of three impartial experts say a treatment isn't necessary, a claimant can feel that at least it wasn't a one-sided hired opinion; they may be more willing to trust that outcome (even if they disagree personally). Overall, patients would experience faster decisions and likely faster access to treatment, which improves satisfaction. They also avoid the degrading experience some have reported of hostile IME exams. A patient could still be examined by a reviewer, but in a professional peer context rather than an insurer-driven context.
- Lawyers and the Legal System: The need for lawyers to intervene in treatment disputes should decrease. Currently, many disputes escalate to legal representatives and the LAT or court, where duelling medical opinions battle it out. With FAIR Care, disagreements would be resolved long before reaching that stage in most cases. As noted, *"the need for lawyers to mediate disagreements could be reduced, as disputes can be resolved faster and more efficiently"*. Plaintiff lawyers might initially worry about losing business, but they would likely see their clients get treatment and benefits with less delay, which is ultimately in the clients' interest. Insurer lawyers would have fewer IME reports to defend in court and could focus on genuine fraud or complex cases. The LAT could see a reduced caseload, or at least the medical treatment issues would be narrower (perhaps the FAIR Care result could even be made binding or admissible, streamlining hearings). This frees up the legal system to handle truly intractable disputes or novel issues, rather than routine treatment tiffs.
- Overall Industry Behaviour: A fair, randomized system encourages all parties to behave more honestly. If you cannot predict or manipulate who will give the second

opinion, the optimal strategy is to be truthful and reasonable upfront. Insurers will approve borderline cases more often (to avoid unnecessary reviews they might lose), and providers will avoid inflating claims (to avoid peer disapproval). It essentially pressures both sides toward the middle, appropriate care, appropriately paid for. Over time, this builds trust and could even reduce the "us vs. them" culture. The industry narrative shifts from catching each other out, to "let's let the chips fall where they may" via unbiased experts. Ideally, this also diminishes "hired gun" culture; doctors who once made lucrative careers being partisan IME examiners might instead participate as neutral reviewers, or not at all. The financial incentive to exaggerate one side's case drops, because whether a reviewer approves treatment or not, they continue to get random referrals regardless, so they might as well stick strictly to the medical facts.

Efficiency and Cost Outcomes

The FAIR Care model promises significant efficiency gains and cost savings:

- **Administrative Savings:** By cutting out IME middlemen, the system saves the administrative fee (often ~$2,000) per assessment that was going to IME companies. If tens of thousands of IMEs occur per year, this is a huge potential savings, which could be redirected to patient care or premium reduction. While there would be some cost to operate the random assignment system (e.g., a small coordinating office or software), it would be modest compared to the current IME industry's overhead. Essentially, money that used to pay for glossy IME reports and coordination would now pay only for the medical professional's time to do a review.
- **Reduction in Prolonged Disability Costs:** Getting treatments approved faster means injuries are addressed sooner, potentially preventing chronic disability. As noted earlier, denial or delay of care often leads to worse outcomes that end up costing more (either to the public system or later settlements). A fair and swift second opinion system ensures that necessary rehab isn't withheld. Patients can recover and return to work sooner, which can reduce long-term income replacement payouts by insurers and lessen the burden on public healthcare (since fewer people will end up in chronic pain programs after being denied timely therapy, a phenomenon seen when insurers or WSIB suppress rehabilitation costs). In Lean terms, this is a huge value gain, better health outcomes with potentially lower total expenditure.
- **Lower Legal and Friction Costs:** Today, a lot of money is spent on lawyers, experts, and the LAT/courts to resolve disputes stemming from duelling medical opinions. If FAIR Care resolves the majority of these disputes administratively, those legal costs plummet. Insurers save on defense costs; claimants' legal fees (often paid on contingency or by insurers when claimants win) also drop. The entire claims cycle becomes more cost-efficient, with less spent-on fighting and more clarity on outcomes. Even the LAT, funded by taxpayer dollars, benefits if its caseload is lighter, freeing resources for other matters.

- **Premium Stability:** While it's hard to predict without actuarial analysis, the expectation is that by removing non-value costs (IME expenses, legal disputes), the system can save money that could reflect in more stable or lower premiums. Currently, Ontario has among the highest auto insurance premiums in Canada, despite the restrictive benefits, partly due to the heavy friction cost load. By targeting those friction costs (which FAIR Care does), any savings could be passed on or at least used to justify not increasing rates. One must note insurers will scrutinize whether the new process awards significantly more treatment (increasing medical payout costs), however, even if medical costs rise moderately because more treatment is approved, that could be offset by the aforementioned savings and by better injury outcomes (reducing other costs like long-term disability). The net effect could be cost-neutral or better for insurers, especially considering that effective rehab tends to mitigate larger claims.
- **Consistent, Predictable Process:** Efficiency isn't just about money; it's also about consistency and predictability, which reduce administrative burden. If all parties know that a treatment dispute will be resolved within, say, a month by impartial professionals, they can plan accordingly. Insurers can set reserves more accurately (no need to account for a wide range of outcomes from a drawn-out LAT hearing). Clinics can manage care pathways knowing they'll get a timely answer on coverage. This predictability is a hallmark of efficient systems; it removes the chaos and variable that currently plague auto insurance claims. Consistency itself can lower costs because processes can be standardized; one submission to FSRA noted the importance of consistency with other payor systems like WSIB. FAIR Care would bring auto insurance closer to the WSIB style of early resolution of treatment issues, which is more systematic.
- **Lean Waste Elimination:** To tie back explicitly to Lean principles, the FAIR Care model *"eliminates unnecessary steps, reduces waste, and focuses on adding value to patient care"*. It leverages existing structures (no reinventing the wheel), yielding *"significant cost savings and a more efficient process overall"*. Those statements encapsulate the efficiency win: we stop doing the redundant things (ordering multiple IMEs, waiting, litigating) and do the necessary thing (get a valid second opinion) in one go.

Legal and Regulatory Considerations

Implementing the FAIR Care model would require some changes to Ontario's regulatory and legal framework, but it could also produce positive legal outcomes:

- **Legislative/Regulatory Change:** Likely, the Statutory Accident Benefits Schedule (SABS) would need amendment to replace the current insurer examination provisions with the new process. FSRA or an appropriate body could be tasked with administering the roster of assessors. Clear rules would outline when insurers can request a review, the timelines, and how the decisions are enforced. These changes would formalize the binding nature of the two-out-of-three rule, making the outcome of the FAIR Care process akin to an administrative decision in the claims process.
- **Appeal Rights:** A question is whether either party could still appeal the result of the third opinion. In principle, if two out of three professionals have spoken, that should

stand as final for benefit entitlement (short of new medical evidence). Insurers might be concerned about no recourse if a clearly non-meritorious claim somehow gets through. Claimants might worry what if the random draw gave two unusually conservative reviewers. A possible safeguard is allowing an appeal to LAT only on demonstrable errors or bad faith in the process, not on mere difference of opinion. But overall, by greatly reducing subjectivity, the need for appeals falls. Embedding this in legislation gives it legal force and reduces later legal wrangling.

- Alignment with Legal Duty of Good Faith: Insurers in Ontario have a duty of good faith toward claimants. A system that ensures impartial decision-making actually helps insurers fulfill that duty. It reduces the risk of bad faith allegations (which have occurred when insurers rely on obviously biased IMEs to terminate benefits). By following the FAIR process, an insurer can demonstrate it acted fairly, it sought an independent peer review. This could lower legal liability for insurers. Conversely, if an insurer tried to ignore the outcome of a FAIR Care review (say two of three said treats, but the insurer still refused), that would clearly be unreasonable and subject them to penalties. So, the legal accountability becomes clearer and in line with fair practice.
- Enforceability and Trust in Evidence: If disputes do proceed to court (e.g., a tort lawsuit for damages might still occur for pain and suffering), the evidence from this unbiased process may carry more weight than dueling hired experts. Judges have expressed frustration with partisan experts in accident cases. A report from a randomly assigned, mutually independent assessor could be seen as more credible evidence than the traditional IME vs. treating doctor standoff. This might even encourage the courts to lean on these reports and discourage each side from calling their own hired experts, simplifying trials. So legally, it can create a species of "trusted neutral evaluation" early in the file that shapes everyone's expectations.
- Consistency and Precedent: Over time, FAIR Care decisions (the majority outcomes) could create a sort of precedent or at least inform best practices. For instance, if in 95% of back injury cases, the second opinion agrees that 12 weeks of physio is reasonable, insurers might stop fighting that altogether and approve it routinely. If a pattern shows certain interventions are usually deemed unnecessary by peers, providers may avoid prescribing them in marginal cases. This leads to de facto standards of care in the auto insurance context, which can evolve as new gold standards emerge. Essentially, the large volume of impartial reviews can generate data on what is reasonable care, guiding policy. Legally, this is far better than a patchwork of inconsistent arbitral decisions that we have now.

In conclusion, the FAIR Care model offers a path to better align the auto insurance claims process with Canadian healthcare norms and legal fairness. It is a shift from an adversarial, inefficient model to a collaborative, efficient one. By using the strengths of self-regulation and impartiality, it promises to reduce conflict and waste. It's not just theory, similar concepts have worked in other systems (for example, some jurisdictions use tribunal-appointed medical assessors to break ties, which has improved outcomes). The key is execution: ensuring random selection is truly random and that all parties buy into respecting the outcome. If done well,

Ontario could become a leader in innovative dispute resolution, replacing costly IME wars with FAIR Care's balanced reviews.

Addressing Counterarguments and Insurer Concerns

Any significant reform like the FAIR Care model will draw questions and critiques, especially from insurers who are accustomed to the current system. It's important to anticipate these counterarguments and respond with evidence and reasoning:

1. Consistency of Decisions: Insurers may worry that random selection of assessors will lead to inconsistent results, that the same claim might be approved by one assessor and denied by another, introducing a "roll of the dice" element. They might argue that under the current system, using a stable of known IME doctors provides more predictability. However, the *status quo is not truly consistent either*. Different insurers use different examiners; even the same IME doctor can be inconsistent, and courts regularly find IME opinions that conflict with each other. In fact, the existing system's inconsistency is what prompted calls for reform, outcomes depend too much on which doctor an insurer chooses. The FAIR model, by using *multiple opinions and majority rule*, actually blunts the effect of any one idiosyncratic view, yielding a more reliable consensus. Two out of three professionals agreeing is a strong indicator of the proper course (this is essentially an application of the "wisdom of the crowd" in expert decision-making). Furthermore, clinical guidelines and standards of practice will still guide all reviewers, providing an underlying consistency. Any significant outlier (say a reviewer who always denies care that most peers support) will be statistically evident and can be addressed by oversight (perhaps removing that person from the roster if they truly are an outlier without justification). Thus, while some variability is inherent, the system is designed to produce a convergent result that is more consistent with broader medical opinion, not less.

2. Quality Control and Oversight: Insurers might question how we ensure the randomly selected assessors are qualified and thorough. Currently, IME firms tout quality control processes (editing, peer review of reports internally), albeit those have been criticized for introducing bias. Under FAIR Care, each assessor works independently. The quality assurance comes from their professional obligations and the fact that another peer might review the same case (in the third opinion scenario). Moreover, all assessors would be credentialed, experienced practitioners and oversight is already provided by the respective Colleges: if an assessor provides a clearly substandard or unprofessional report, they could face a complaint. It's notable that currently, many IME doctors operate with little oversight, complaints to regulators are rare and discipline rarer, even for those known to provide problematic reports. A system integrated with the Colleges (perhaps reports could even be audited by the Colleges as part of their quality programs) might enhance accountability. Insurers also worry about "who watches the watchmen", but since neither side is picking the assessor, there's mutual interest in ensuring the roster is filled with reputable, neutral professionals. A governance body (with insurer, and claimant representatives, perhaps chaired by FSRA or health professionals) could oversee the roster selection and address any performance issues. Overall, the neutrality of the process is itself a form of oversight, because it removes suspicion that the assessor is biased. And with multiple

data points (in some cases three opinions), the chance of a rogue decision slipping through is minimized.

3. Cost Control and Potential for Increased Treatment:

One of the biggest insurer concerns will be: *Won't this system just rubber-stamp treatments and drive-up costs?* They might argue that treating providers will always prescribe more therapy, and fellow providers may be inclined to agree out of collegial sympathy or a bias toward more treatment, leaving the insurer paying more. There are several rebuttals:

- The Globe analysis of hundreds of cases found many IME doctors who were overzealous in denying severity. That suggests the balance might currently be tilted too far toward denial. A neutral system could actually just correct that tilt, covering necessary care that should have been covered to begin with, which in turn improves outcomes and can *reduce overall costs* (no prolonged disability or expensive chronic care due to under-treatment).
- Second, the majority-rule safeguard prevents rubber-stamping. If a treating provider truly is over-treating, it's likely at least one of the two reviewers will say so, and if one agrees and one disagrees, the third opinion will break the tie. It's not true that "providers will always side with providers", professional integrity and evidence-based guidelines will guide decisions. Remember, these reviewers have no relationship with the treating clinic; they are not assessing their own patient but someone else's, so they can be objective. Also, they know their name is on the line in a report that could be reviewed or appear in a legal file, so they have incentive to be evidence-based, not lenient or harsh.
- Third, even if more treatment gets approved in some cases, the elimination of wasteful costs (IMEs, disputes) provides a buffer. For example, approving an extra $1,000 of therapy is far cheaper than spending $2,000 on an IME to possibly deny that therapy. Financially, it may make sense to err on the side of treatment, especially if earlier intervention prevents chronic claims. This is aligned with the principle that investing in proper care yields savings (as opposed to the false economy of denial, which often shifts costs to the public system or later insurer costs). Lean thinking is about removing non-value costs so value-generating activities (like effective treatment) can proceed.
- Insurers also value *consistency in cost control*; they fear an unpredictable system where suddenly they cannot forecast medical spend. However, as argued, FAIR Care should provide consistency at a higher level (macro patterns of what's deemed reasonable). Insurers can be part of setting any guidelines the reviewers use. For instance, through consultation, stakeholders might agree on baseline treatment duration for certain injuries, etc., which peers would consider. The difference is those guidelines would be medically driven, not arbitrarily low caps. Yes, medical claim costs might rise in justifiable ways (e.g. covering inflation-adjusted therapy rates or longer rehab for truly catastrophic injuries), but those are offset by saved legal costs and better outcomes.

In essence, cost control should not equate to blanket denial of care, it should mean delivering needed care efficiently. FAIR Care addresses efficiency and appropriateness; it doesn't give a

blank cheque to providers. It still filters out unnecessary treatments via peer review, just without the conflict of interest.

4. Implementation Practicality: Some may question whether it's feasible to randomly assign assessors and get quick turnarounds. Ontario is large, can we ensure availability of qualified reviewers in all regions and in all disciplines (physiatry, ortho, psych, chiro, physio, OT, etc.)? The answer likely lies in modern technology and province-wide coordination. The Health Claims for Auto Insurance (HCAI) system already connects all licensed provider clinics; it could be augmented or a new platform built to facilitate referrals. We know WSIB has successfully contracted providers across the province for specialized assessments when needed (and WSIB even uses the Telus Health eClaims portal for streamlined billing). So technically, it's very plausible. As for clinician willingness: many healthcare professionals would welcome the chance to earn income doing neutral reviews, especially if it helps fix a system they currently find frustrating. One might even involve professional associations to help manage rosters. The transition is an administrative challenge, but not an insurmountable one, and certainly worth the effort given the potential benefits. Policymakers could pilot the approach on a small scale first (for example, only for disputes about a certain treatment category or in a specific region) to work out kinks before scaling up.

5. Resistance to Change: Finally, an unspoken counterargument is inertia, the current IME industry and some insurers might resist because it upends existing relationships and business models. IME companies benefiting from the status quo may lobby against such reform. Insurers may have trusted go-to examiners and fear the unknown of a new system. To that, the response is that the evidence of dysfunction in the current model is overwhelming. From high costs, to damning media investigations (e.g., judges calling out $38,000 assessment fees, or doctors making $800k a year mostly doing IMEs), to regulator and public discontent, it's clear the system isn't serving accident victims or the insurance-buying public well. Even insurers publicly admit concerns about IME quality and impartiality. Thus, clinging to the status quo is not tenable. Change is coming, and it's better that insurers help shape a fair solution than have one imposed. In fact, FAIR Care gives insurers a fair shake too, they won't be paying for as many dubious treatments or facing as many huge legal battles.

In summary, while insurers and others may raise valid questions about consistency, oversight, and cost, the FAIR Care model has strong answers to these concerns. It provides consistency through consensus, oversight through peer accountability, and cost control through waste elimination and early resolution. It aligns incentives correctly, which is the surest way to control costs in the long run. Ontario can draw on lessons from healthcare and other insurance systems to ensure the model is implemented smoothly. By addressing these counterarguments head-on, stakeholders can refine the model and build confidence that this approach will lead to a more sustainable, fair, and efficient auto insurance system.

Conclusion

Ontario's auto insurance IME system, as it stands today, is a product of decades of incremental changes aimed at controlling costs and fraud, but it has evolved into a bureaucratic and adversarial maze that often works against the very goals of timely care and fair compensation. The analysis in this briefing has shown that the major IME providers are in many cases tied to foreign corporations, raising issues of data privacy and alignment with Canadian values. The current model duplicates the checks and balances already present in our healthcare system and the WSIB, resulting in added cost, delay, and a breakdown of trust. From a Lean perspective, the insurer-driven IME process is laden with waste: duplicate exams, waiting, transportation, rework (disputes), and misused expertise. These inefficiencies ultimately harm both claimants, who endure delayed recovery and skepticism, and insurers, who pay for a costly dispute apparatus and suffer reputational damage.

Fortunately, Ontario has the opportunity to re-imagine dispute resolution in a way that leverages what is best about our healthcare system: professional integrity and peer accountability. The FAIR Care model of randomized second and third opinions offers a compelling blueprint. By entrusting medical disagreements to neutral, qualified peers and removing the ability of either side to tip the scales, it promises to deliver faster, fairer outcomes. It aligns with Canadian norms (no treatment decision by an insurer without independent medical justification) and with efficient process design (get it right the first time, minimize non-value steps). Early analysis suggests such a model would reduce administrative overhead, focus resources on care, and likely improve overall system outcomes, benefiting claimants, insurers, and public confidence alike.

Implementing these reforms will require leadership and open-minded collaboration among regulators, insurers, healthcare providers, and legislators. Change can be challenging, but as this review has emphasized, maintaining the status quo carries its own high costs and harms. A senior policy advisor or elected official reviewing this evidence should recognize that Ontario's goals of affordability, sustainability, and compassion in auto insurance are best served by a leaner, more transparent system that trusts in regulated professionals and objective processes rather than adversarial one-upmanship. Such reform aligns with broader provincial priorities of reducing red tape and strengthening public trust in institutions.

In conclusion, Ontario's auto insurance can move beyond the current IME regime, which has been described in court as producing "anything but impartial" results, to a Fair Care system that truly puts the patient's recovery and fairness at the centre. By doing so, we would not only eliminate redundancies and save costs, but also uphold the principle that medical necessity, not financial strategy, guides the care of accident victims. This is a principled and practical path forward, one that this briefing recommends be pursued earnestly as part of ongoing auto insurance reforms.

Sources

Corporate Ownership and Acquisition Records

- **U.S. Securities and Exchange Commission**

  Asset Purchase Agreement between ExamWorks Group, Inc. and Direct IME Corp. (2010).

  https://www.sec.gov/Archives/edgar/data/1498021/000118811210002121/e39638ex10_8.htm

- **Fasken Martineau DuMoulin LLP**

  ExamWorks Canada – Completion of Multiple Major Acquisitions (2023).

  https://www.fasken.com/en/experience/2024/04/examworks-canada-completed-several-major-acquisitions

Investigative Journalism and Legal Commentary on IMEs

- **The Globe and Mail**

  Doctors who conduct insurance "independent medical examinations" are often anything but impartial.

  https://www.theglobeandmail.com/news/investigations/doctors-insurance-independent-medical-examinations/article37141790/

- **DD Injury Law**

  Independent medical examinations are often found to be anything but impartial (summary and excerpts of Globe and Mail investigation).

  https://www.ddinjurylaw.com/blog/post/independent-examinations-are-often-found-to-be-anything-but-impartial

- **Greg Monforton & Partners**

  Independent Medical Examination Investigation (2017) – summary and analysis of Globe and Mail reporting.

  https://www.gregmonforton.com/blog/independent-medical-examination-investigation.html

Corporate Finance and Ownership

- **Reuters**

  Warburg Pincus invests in Canadian insurer SCM Insurance Services (parent company of Cira Medical Services).

  https://www.reuters.com/article/business/warburg-pincus-invests-in-canadian-insurer-scm-insurance-idUSKCN1BB25K/

Industry Profiles

- **Canadian Underwriter**

  Cira Medical Services opens discussion on IME industry-wide change (2013).

  https://canadianunderwriter.ca/partner-content/announcements/inspress/cira-medical-services-opens-discussion-on-ime-industry-wide-change/

Regulatory and Policy Context

- **Financial Services Regulatory Authority of Ontario (FSRA)**

  Consultation submissions on auto insurance reforms (2023), including analysis of insurer examinations, treatment disputes, and system design considerations.

  (Submission by Anthony Grande)

- **Ontario Statutory Accident Benefits Schedule (SABS)**

  Legislative and regulatory framework governing insurer examinations, treatment plans, and benefit entitlement in Ontario auto insurance.

TABLES AND DIAGRAMS

FAIRcare Process Flow Diagram

The following outlines a typical FAircare process in the context of independent medical examinations (IMEs) and insurer examinations as related to the Ontario regulatory environment:

- **Referral Received**: Claimant's case is referred to FAircare for an independent medical assessment.
- **Case Review & Triage**: FAircare reviews documentation, determines assessment requirements, and assigns an appropriate medical expert.
- **Appointment Scheduling**: Appointment is coordinated between the claimant, medical expert, and other relevant parties.
- **Assessment Conducted**: Clinician performs the assessment, gathers clinical findings, and reviews supporting documents.
- **Report Preparation**: Clinician prepares a short response to two question:

  1-Will continued treatment assist the patient? Yes/No

  2-How will continued treatment assist the patient?

- **Report Delivery**: Final report is sent to the original clinician, referring insurer and legal counsel for resolution.
- **Follow-up & Clarifications**: Any additional questions or requests for clarification are addressed as needed.

This process is designed to ensure transparency, regulatory compliance, and fairness for all parties involved.

Table 1: Ontario Insurance Examination Providers

Table 1 – Ontario Insurance Examination Providers

Purpose: Identify the major organizations that perform insurer-requested medical assessments (IEs/IMEs) in Ontario's auto insurance system, including their ownership and scope.

Legal Entity Name	Operating / Trade Names	Ontario Licence Status	Type of Examination Services	Primary Insurer Clients	Parent Company	Ultimate Ownership Jurisdiction	Notes on Market Presence or Scale
Lifemark Health Group – AssessMed & Viewpoint	AssessMed (medical assessments); Viewpoint (Lifemark IME division)	FSRA-licensed as health clinics (AssessMed itself not required to hold separate license for IEs)	Insurer examinations (IE/IME), paper file reviews, catastrophic impairment assessments, med-legal evaluations	Not publicly disclosed (serves multiple Ontario auto insurers)	Shoppers Drug Mart (Loblaw Companies Ltd.)	**Canada (Ontario)**	Canada's largest IME provider (175+ locations via Viewpoint) . Lifemark acquired AssessMed in 2019, integrating a national IME service into its clinic network . Over 300 rehab clinics across Canada (Ontario-based) give it significant market share.
SCM Insurance Services – Health Solutions	Cira Health Solutions (formerly Cira Medical); also operates legacy brands Sibley & Associates, Total Rehabilitation Management (TRM), Multi-Disciplinary Assessment Centre (MDAC)	Not required (assessment-only providers; no direct billing of accident benefits)	Insurer independent medical exams (IME/IE), file reviews (paper reviews), catastrophic injury assessments, disability evaluations	Not publicly disclosed (contracts with multiple insurers)	SCM Insurance Services (Toronto)	**Other – foreign-backed**	National IME and assessment provider integrated in a large claims services group. Formed via mergers of Cira and Granite's health divisions . Majority-owned by private investors (historically Ontario-based TorQuest; now includes U.S./U.K. private equity) . Significant Ontario market presence through insurer contracts, though branding is fragmented (Cira, Sibley, etc.).
ExamWorks (Canada Operations)	ExamWorks Canada Inc. and subsidiaries: Direct IME; SOMA Medical Assessments; North York Rehabilitation Centre (NYRC); Capital Vocational Specialists; Makos Health; KRA Health; others	Not required (assessment-only providers; operate as vendors to insurers)	Independent medical examinations (all disciplines), peer record reviews, functional capacity evaluations, employer IMEs, Medicare/medicolegal reviews	Not publicly disclosed (serves multiple auto insurers, WSIB, legal firms)	ExamWorks, LLC (Atlanta, GA)	**United States**	One of the largest IME conglomerates. Entered Canada by acquiring numerous Ontario IME firms (e.g. Direct IME in 2010) . Operates a consolidated network of assessment centers across Ontario . Foreign-owned with global operations (U.S., Canada, UK, Australia) . Significant share of Ontario insurer exams, with centralized processes and technology.
CBI Health Group – Assessments	CBI Health Centres; CBI Assessment Services (e.g. "CanAssess" program)	FSRA-licensed as health service provider (for clinic billing)	Treatment provider multidisciplinary assessments, **plus** independent medical evaluations (IME) and functional ability exams	Not publicly disclosed (likely multiple insurers via preferred-provider arrangements)	CBI Health Group (Private)	**Canada (Ontario)**	Large Ontario-based rehab network (over 13,000 health professionals nationally) . Offers insurer-requested IMEs alongside patient treatment. Historically backed by Ontario pension funds (OMERS); its home-care division was sold to Extendicare . Operates dozens of clinics in Ontario, often acting as a preferred referral network for insurers' claimants.
							Note: "Not required" under *Ontario Licence Status* indicates no special provincial facility license is needed solely to perform insurer-requested medical assessments (as these firms do not bill accident benefits directly). *Primary Insurer Clients* are generally not publicly disclosed; most listed firms serve a broad range of Ontario auto insurers. The above list focuses on major players – many smaller independent IME providers exist, but a few corporate groups (often foreign-owned) conduct the bulk of insurer examinations

Table 2: IE Corporate Ownerships and Structure

Table 2 – Corporate Ownership & Control Structure

Purpose: Map the ownership, corporate structure, and level of external (non-Ontario) control of key organizations in the auto insurance medical assessment market.

Operating Entity / Group	Parent Company	Ultimate Controlling Entity	Country of Incorporation	Ownership Type	Shared Services or Centralized Functions	Cross-Border Control Indicators
Lifemark Health Group (incl. AssessMed & Viewpoint)	Shoppers Drug Mart (Loblaw Companies)	Loblaw Companies Ltd. (publicly traded, Canadian-owned)	Ontario, Canada	Public company (TSX: L)	Yes – integrated corporate functions across clinics and assessment division (finance, IT, HR are centralized)	None – Ownership and management based in Ontario (Canadian control). Lifemark was previously U.S. private equity-owned (Audax, 2016–2022) but is now under a Canadian parent.
SCM Insurance Services – Health Solutions (Cira, Sibley, etc.)	SCM Insurance Services, Inc.	**Davies Group Ltd.** (private, UK-based) – pending integration	Alberta/Canada (operating company)	Private (PE-backed)	Yes – shared corporate infrastructure within SCM (common management for claims adjusting, IME division, etc.)	**High** – Majority ownership by foreign private equity (Warburg Pincus (USA), BC Partners (UK)). Strategic decisions and capital ultimately controlled from outside Ontario.
ExamWorks Canada (ExamWorks Inc. and subs)	ExamWorks, LLC (wholly-owned subsidiary of ExamWorks Group)	ExamWorks Group – owned by CVC Capital Partners (Luxembourg/UK fund) and co-investors	Delaware, USA (holding co.)	Private (PE-owned)	Yes – acquisitions operate on a unified platform with centralized scheduling, reporting and IT systems . Local subsidiaries share services via ExamWorks.	**High** – Global headquarters in the U.S. (Atlanta) . Corporate governance and profit distribution reside outside Canada (major stakeholders from US, Europe, Singapore).
CBI Health Group (clinics & assessments)	CBI Health Group (private partnership/LP)	CBI investors – e.g. OMERS (Ontario pension) and management; **Extendicare Inc.** (public, Canada) for home-care division	Ontario, Canada	Private (institutional investors)	Yes – centralized corporate services across all clinics (single management team for treatment clinics and assessment services)	**Low** – Ownership and control largely within Ontario/Canada. No significant foreign controlling entity (Ontario healthcare investors).

Notes: "Shared Services" refers to whether key functions (e.g. administration, IT, billing systems) are centralized across a group's assessment and/or treatment units. "Cross-Border Control" indicates if strategic

Table 3: Treatment Provider Networks Receiving Insurance Referrals

Table 3 – Treatment Provider Networks Receiving Insurer Referrals

Purpose: Identify rehabilitation treatment networks and clinics to which auto insurers frequently refer claimants (sometimes via **Preferred Provider Networks (PPNs)**), and note any formal "preferred provider" status or ownership details.

Treatment Provider / Network Name	Type of Care	Referral Source	Preferred Provider Indicators	Ownership Entity	Ontario-Based Operations
Lifemark Health Group – Clinic Network (incl. pt Health, Preferred Rehab, etc.)	Physiotherapy, chiropractic, occupational therapy, massage, concussion & multidisciplinary rehab programs	Typically insurer or adjuster referral (in addition to doctor or self-referral); **common choice for insurer-directed programs** (e.g. minor injury rehab)	**Yes (Informal/Formal):** Often part of insurers' preferred networks – some insurers contract for pre-approved treatment rates and quick access . Lifemark confirmed it acts as a preferred provider for certain insurers (open network claims) *(source: Globe & Mail via Stockwatch)* .	Shoppers Drug Mart (Loblaw) – Lifemark Health Group division	Yes – ~300 clinics across Ontario & Canada.
CBI Health Centres (CBI Health network)	Multidisciplinary rehabilitation (physio, kinesiology, chiropractic, psychology, etc.)	Insurer referrals (especially for case-managed rehab); also used by lawyers and employers	**Yes (Informal/Formal):** Participates in insurer referral programs and contracts (industry reports note use of networks). Likely offers **pre-set service bundles** and direct billing arrangements for insurers' accident benefit claims.	CBI Health Group (private, Canadian)	Yes – extensive clinic network in Ontario (over 60 Ontario facilities, part of ~200 nationwide).
Independent Preferred Provider Networks (PPNs) – *Multiple small clinics*	Varied (physiotherapy, chiropractic, etc., often for minor injuries)	**Insurer-directed**: claim adjuster steers claimant to an **insurer-selected clinic network**	**Yes (Formal):** Contractual insurer networks with pre-approved fees and treatment plans. Claimants are referred by insurer; participation requires consent but insurers may incentivize use. These PPN arrangements typically cap costs and streamline approval .	Varies – individual private clinics (some local, some part of larger chains)	Yes – clinics operate in Ontario communities (insurer networks may span urban and regional areas).
					Note: Insurers are legally not supposed to *require* claimants to use a specific provider, but in practice, "preferred provider" networks are used to manage costs and care consistency . Lifemark and CBI, as large chains, are frequently utilized for such referrals due to their scale and coverage. Smaller clinics also join insurer networks through formal agreements. "Referral Source" here highlights that the insurer or claims adjuster often initiates or encourages the claimant's use of these providers, as opposed to the claimant's own doctor or choice.

Table 4: Corporate Connectivity Between IE Facilities and Treatment Providers

Table 4 – Corporate Connectivity Between Exams and Treatment

Purpose: Illustrate where the same corporate groups engage in **both** insurance medical examinations **and** treatment services, indicating vertical integration that might pose independence risks.

Corporate Group	Provides Insurance Examination Function?	Provides Treatment Delivery Function?	Shared Ownership of Both Functions?	Shared Management or Branding?	Shared Data / Admin Infrastructure?
Lifemark Health Group (Viewpoint Assessments + Clinics)	**Yes:** Owns IME companies (Viewpoint, AssessMed) conducting insurer examinations .	**Yes:** Owns rehab clinics (physio, etc.) delivering treatment to claimants.	**Yes:** Same parent company owns both IME division and treatment clinics.	**Yes:** Unified corporate leadership; though IME units retain trade names, all are under Lifemark/Shoppers management. Branding is linked (e.g. "Viewpoint, a division of Lifemark").	**Yes:** Back-office functions and systems are integrated (shared booking systems, client data access, etc., within legal privacy limits). The group can coordinate assessments and treatment internally.
SCM Insurance Services (Health Solutions)	**Yes:** Provides insurer examinations (Cira, Sibley, etc.) .	**No:** Does **not** directly operate treatment clinics for claimants (focus is on assessments and related services).	**N/A:** (No treatment arm within SCM to share ownership with the IME arm).	**No:** IME companies share management within SCM, but no treatment unit in corporate structure.	**No:** IME operations are separate from any healthcare delivery networks (SCM's shared services are with its claims adjusting and investigative units, not treatment providers).
ExamWorks Inc. (ExamWorks Canada)	**Yes:** Exclusive focus on IMEs, peer reviews, and claim evaluations .	**No:** No patient treatment services (no rehab clinics; business is purely assessments).	**N/A:** (No treatment services owned).	**No:** Not applicable – ExamWorks manages multiple assessment brands, but owns no treatment clinics to "share" management with.	**No:** Data systems are centralized for exams, but there is **no crossover with treatment data** (any treatment is outside this corporate group). ExamWorks' role ends at the assessment report.
CBI Health Group	**Yes:** Has an IME/assessment division (part of its rehab services) .	**Yes:** Operates extensive treatment clinics network for physiotherapy, etc.	**Yes:** Same organization handles both independent assessments and ongoing treatment services.	**Yes:** Shared management – assessment services are managed alongside clinical operations within CBI. All carry the CBI brand.	**Yes:** Likely – common IT systems, client records (some treatment clinics also perform insurer assessments). Potential for information-sharing internally (subject to consent and privacy laws) since both functions under one roof.
					Key observations: Lifemark and CBI illustrate vertical integration, owning clinics that treat accident victims and units that conduct "independent" exams for insurers – raising potential conflicts (the company might assess a claimant's needs through an IME and then provide the treatment, or vice versa). By contrast, ExamWorks and SCM's Cira/Sibley units are purely assessment-focused, separate from treatment delivery (avoiding internal conflict, but still hired by insurers). Shared data/admin infrastructure in integrated groups can create efficiencies but also blur lines between evaluator and caregiver roles.

Table 5: Regulatory Duplication, Gaps and Oversight Fragmentation

Table 5 – Regulatory Duplication, Gaps and Oversight Fragmentation

Purpose: Outline how **different bodies oversee different aspects** of auto insurance medical assessments and care, and where oversight overlaps or is siloed. This highlights complexity rather than regulatory failure.

Activity	Governing Body / Oversight	Regulatory Basis	Duplication with Existing Healthcare Oversight?	Administrative Burden Indicators
Insurance Medical Examinations (IE/IME assessments)	*Primary:* Health profession regulators (e.g. College of Physicians & Surgeons of Ontario, College of Psychologists, etc.) oversee individual examiners' professional conduct. *Secondary:* Financial Services Regulatory Authority (FSRA) – **no direct licensing of IME firms** (SABS rules allow insurers to request IEs, but IME companies themselves are not specifically regulated by FSRA) .	**Regulated Health Professions Act** (RHPA) – standards for medical professional behavior; **Insurance Act (SABS)** – provisions for insurer examinations (e.g. when an insurer can require an exam, rights of claimants, etc.).	**No direct duplication.** Oversight of examiners is almost entirely through existing health regulatory colleges. FSRA's oversight is indirect (ensuring insurers adhere to SABS process). No separate Ontario licensing for IME companies means **limited overlap** – rather, a gap in dedicated oversight of assessment businesses.	*Moderate:* IME providers and assessors must follow professional rules, but face **no additional licensing compliance** specific to insurance sector. This reduces red tape, but also means quality control relies on health colleges (which may not actively monitor IME quality issues).
Treatment of Accident Injury Claimants (Rehabilitation clinics and providers)	*Dual:* **FSRA** – licenses and audits health clinics that bill auto insurers (business practices, billing integrity) ; **Health Regulatory Colleges** – regulate clinicians (quality of care, ethical standards). *(This single body already covers all oversight.)*	**Insurance Act & Regulations** (e.g. Ontario Reg. 90/14 for service provider licensing, SABS for billing rules); **RHPA & Health Profession Acts** (for clinical care standards and provider qualifications).	**Yes – Duplication exists.** Accident-rehab clinics must answer to two systems: FSRA's compliance (focused on billing and administrative conduct) and traditional healthcare regulators (focused on clinical practice) . The oversight roles overlap; e.g. both FSRA and colleges address certain professional conduct issues, and providers pay fees to both systems. This parallel oversight is a concern raised by providers as **inefficient duplication** .	*High:* **Red tape burden** on providers – clinics must maintain redundant FSRA licences, undergo audits and file reports , **in addition** to meeting all health-college which are more comprehensive than FSRA requirements. Extra documentation (OCF forms, HCAI electronic billing) and compliance checks add administrative costs beyond normal healthcare operations.
Claims Administration (Insurer decision-making, referrals, and cost control processes)	**FSRA** – oversees insurers' compliance with the Insurance Act and SABS (timelines, fair claims practices; can sanction unfair or deceptive acts). **License Appeal Tribunal (LAT)** – adjudicates disputes (quasi-judicial, not a regulator). *No health-system oversight:* Insurer claim handling is not governed by health authorities.	**Insurance Act & SABS** – sets rules for claims processes (e.g. timelines for approvals, ability to impose insurer exams, fee schedules). **FSRA Rules/Guidelines** – e.g. Unfair or Deceptive Acts or Practices (UDAP) rules for insurers.	**No,** distinct domain. Insurance administration is separate from healthcare regulation. (E.g. an adjuster's referral to a clinic is not overseen by any health college – only general insurance conduct rules apply.) However, **lack of overlap** can leave gaps: decisions about care funding are made outside the healthcare system's purview.	*Moderate:* Claimants and providers navigate **two parallel systems** – medical and insurance. Numerous forms (e.g. OCF-18 treatment plans, OCF-21 invoices) and **HCAI** electronic submissions are required by FSRA's framework, on top of regular medical charting. This dual process increases complexity and administrative steps (for example, a therapist must get insurer approval via forms that are not part of ordinary healthcare workflow). The fragmentation can lead to delays and confusion in coordinating patient care and reimbursement.
				Note: The table illustrates that no single authority oversees the entire "insurance medicine" ecosystem. Instead, multiple bodies have partial oversight: Health regulators ensure professionals behave ethically but do not specifically address insurer-driven conflicts; FSRA ensures financial and procedural compliance but explicitly does not cover clinical quality . This can result in both gaps (e.g. IME companies not subject to direct regulation beyond general business law) and overlaps (e.g. clinics answering to two regulators for similar issues). The complexity adds administrative cost and can obscure accountability, even when each regulator is performing its intended role.