

2014

Ontario Automobile Insurance Dispute Resolution System Review

Final Report

February 2014



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ONTARIO AUTOMOBILE INSURANCE DISPUTE RESOLUTION SYSTEM REVIEW

FINAL REPORT

Introduction

A review of the Ontario auto insurance dispute resolution system (DRS) was first announced in the 2012 Ontario Budget. The 2013 Ontario Budget committed to the appointment of an expert to review the system and propose legislative amendments in the fall of 2013.

On August 23, 2013, I was appointed by the Ontario Minister of Finance, the Honourable Charles Sousa, to conduct a review of Ontario's DRS. I was assigned two tasks:

- Deliver an interim report in the fall of 2013 that considers whether mediation should remain mandatory for Ontario auto insurance disputes, and how best to deliver auto insurance dispute resolution in Ontario — through government, the private sector, or a combination of both.
- Deliver a final report by February 2014, that provides recommendations regarding systemic causes of and solutions to the mediation backlog, potential changes to the current structure, a delivery model and process, the addition of a dispute prevention process for the system and other issues related to the viability of the DRS.

My interim report was submitted to Minister Sousa on October 31, 2013. This is my final report, which summarizes consultations with stakeholders on the interim report, provides recommendations to address systemic problems within the DRS and proposes a new delivery model and process.

Once again, I would like acknowledge the assistance of Mr. Murray Segal, a former Deputy Attorney General of Ontario, Mr. Willie Handler, an authority on the Ontario auto insurance system, and the staff from the Ministry of Finance and the Financial Services Commission of Ontario (FSCO).

Trends and Challenges

The interim report highlighted a number of trends and challenges for the current DRS:

- Demand for DRS services remains high, although demand did fall off somewhat in 2013;
- While stable at present, average settlement amounts were continuously rising until 2010;
- Treatment is the most common disputed issue;
- The GTA drives much of the demand for mediation and arbitration services;
- Mediation applications more than doubled from 2007-08 to 2011-12 despite no increase in motor vehicle accident (MVA) injuries; and
- The number of MVA claims accessing the courts has also been increasing since 2010.

Consultations

Following my appointment to lead this review in August 2013, auto insurance stakeholders were invited to provide me with submissions with their perspectives on the Ontario auto insurance DRS. After reviewing the submissions and prior to submitting my interim report, I had extensive meetings with stakeholders to discuss issues raised in their submissions.

Following the release of the interim report by the Ministry of Finance, a second round of consultations was conducted, consisting of written submissions followed by in-person meetings in December 2013.

DRS Principles

In my interim report, I listed a number of principles with respect to dispute resolution as part of my preliminary observations:

- 1. Timeliness:** The DRS should provide quick access to dispute resolution services without the need to go to court in order to facilitate timely treatment.
- 2. Proportionality:** The DRS should accommodate different processes based on the complexity of the case.
- 3. Accessibility:** Claimants should be able to access the DRS whether or not they are represented and without concern for financial resources.

4. Predictability: The DRS outcomes should provide users with a reasonable level of certainty and predictability, so that insurers can properly set reserves and charge premiums reflective of risk, and claimants can reasonably understand what their auto insurance coverage provides.

5. Streamlining: DRS processes should be quick and simple with a minimal amount of paper.

6. Costs: The DRS should be cost-efficient and reflect the economic imbalance between claimants and insurance companies. The cost structure should also discourage abuse of the system.

7. Culture: The DRS should promote a positive culture among stakeholders and encourage early resolution of disputes.

A Framework for Possible Legislation as Set Out in the Interim Report

The interim report proposed a possible new model and stakeholders were invited to provide feedback. The proposed model covered the principles of timeliness, proportionality, accessibility, predictability, streamlining and cost efficiency while promoting a positive culture. The interim report proposed the following:

- I envisioned a process that would take no longer than six months from start to finish. Cases would follow different streams based on the benefits in dispute and the complexity of issues involved.
- The process would begin with a benefit denial. Every Ontario auto insurance company would have to establish a formal internal review process. This process would take place within a 30-day window.
- If the parties could not resolve their dispute, the claimant would then file an application with the new DRS provider or perhaps access the courts at the outset.
- If the claimant chose the DRS provider, a case manager serving as a gatekeeper to the system would review each application to determine whether the parties were ready to proceed. The case manager would have the ability to return the application if there were any outstanding issues of non-compliance.
- Once everything was in order, the case would immediately be assigned and a mediation session arranged within 45 days. During the enhanced mediation session, a non-binding opinion on the likely outcome might be provided. Should the mediation fail to produce a settlement, the arbitrator would immediately schedule a hearing for the parties.

- The arbitrator would also perform a triage role at this point to determine whether a case should be subject to a paper review, an expedited in-person hearing or a full in-person hearing.
- Expedited hearings would take no longer than half a day. More complex cases, such as catastrophic impairment determinations, would also be limited to a specific timeframe.
- A paper review would take place within 60 days of the mediation, while in-person hearings would take place within 90 days.
- Rules would be established in regulations setting out timelines, sanctions for non-compliance and related provisions. There would be a prohibition on adjournments in all but the most exceptional cases.
- Fees would differ depending on the type of hearing.
- Decisions would be issued within 45 days of an in-person hearing. For paper reviews, decisions would be issued within 30 days. The process from application date to the issuing of a decision would be four-and-a-half months for paper review arbitrations and six months for in-person arbitrations.
- There would be the ability to fast-track some issues through the DRS and ultimately to the courts, if necessary, to obtain early rulings in relation to new amendments to the Statutory Accident Benefits Schedule (SABS).
- Appeals of arbitration decisions would be heard by a single judge of the Superior Court.

Feedback on the Interim Report

I very much appreciate the feedback I received on my interim report from stakeholders and users of the DRS. There were 33 submissions received and many excellent in-person meetings. It was obvious that the groups and individuals had put a great deal of time and thought into their responses. If there was any common theme across all submissions, it was the importance of this review and its outcome.

The DRS review is one of a number of auto insurance initiatives currently being undertaken by the government. These other initiatives frequently came up in discussions with stakeholders as people tried to sort out how possible changes might impact them. However, my mandate was limited to reviewing the DRS and I leave it to others to pull all the different initiatives together.

One of the things I quickly realized during the DRS review was how polarized the system has become. I am certain that when the first no-fault auto insurance system was introduced in 1990, policymakers did not contemplate that the claims process and the DRS would become so adversarial. This was very much reflected in the feedback received from stakeholders. The insurance industry points to the plaintiff bar as the source of the system's problems, while the legal community blames the practices of the insurance industry. Neither is an accurate portrayal of the current system.

Some stakeholders have argued that, since the mediation backlog has been addressed, there is no need for reform. I believe this position is short-sighted and that systemic issues remain. In fact, the backlog has now resurfaced in the arbitration system and demand for dispute resolution services remains high. I found there was no consensus on the extent of the problems within the system and, therefore, the need for reforms. However, there is agreement that the principles I had set out in the interim report should apply to the DRS.

Increase in Utilization

A number of stakeholders provided their perspectives on why the volume of mediation applications rose from 2006 to 2012. I believe it is important to examine those views to better understand the systemic issues requiring attention.

Some stakeholders suggest that the increase in applications was triggered by the elimination of the designated assessment centres (DACs). DACs were created in 1994 to provide neutral, multidisciplinary assessments of treatment requests, attendant care needs, disability and catastrophic impairment. Despite the criticism directed at the DACs, they provided some balance between competing opinions provided by the claimant's treating health care providers and the insurer's independent medical assessors. Although the DACs were intended to provide neutral assessments, a number of stakeholders felt the DACs were biased. FSCO was responsible for the administration of the DAC system, which involved issuing assessment guidelines, establishing timelines and standardized reports, reviewing the qualifications of assessors and introducing a quality assurance program. The DAC system was eliminated in 2005.

Insurers were required to send a claimant to the DAC closest to the claimant's home, which reduced the ability of parties to pressure assessors. There was a presumption that they would be more objective. As well, DAC decisions were binding on the parties, subject to dispute resolution if one of the parties disagreed. Even though arbitrators did not give greater weight to an opinion from a DAC, there was a level of acceptance by both insurers and claimants. In contrast, today's insurer examination (IE) reports appear to have little credibility with claimants and only serve to trigger disputes. Unlike the DACs, IE assessors are not accountable to FSCO, have no standard assessment protocols, report formats or timelines and are not insulated from outside influence. In hindsight, the DACs may have had a positive impact on reducing the number of disputes in the system. I will return to independent medical consultants and assessments later in this report.

Some have suggested that the 2010 auto insurance reforms contributed to the increase in mediation applications. I don't believe FSCO's statistics support this perception. In an effort to control spiralling claims costs, the government reduced, or in some cases eliminated, certain mandatory accident benefit coverage. Prior to the reforms being introduced in September 2010, the number of benefit applications shot up in an effort to take advantage of flaws in the outgoing system. Data provided by FSCO shows that the DRS was clogged by disputes arising from claims preceding the reforms.

I acknowledge that new terminology was introduced into the SABS in 2010, including "incurred expenses," "minor injury," "predominantly a minor injury" and "compelling evidence." Those terms have been subject to varying interpretations, which are being challenged in the DRS. A number of stakeholders noted that a significant number of current disputes involve claimants attempting to access the higher level of benefits by avoiding having their injuries classified as "minor." Over time, these disputes may decrease once there is clarification as to which injuries are included in the minor injury definition.

Finally, a number of stakeholders point to anti-fraud measures adopted by insurers, which they suggest have led to higher denial rates by adjusters. A bulletin issued by the Superintendent in March 2011 reminded insurers of their rights and responsibilities under the SABS to challenge questionable or abusive claims.¹ I am not in a position to comment on the extent of fraud in the auto insurance system. In 2011, the government established the Automobile Insurance Anti-Fraud Task Force, which made recommendations in 2012 that the government is still implementing. I am also unable to point to any predominant issue that I can say has increased use of the DRS. As anyone familiar with auto insurance in Ontario knows, the system is complex and no doubt there are numerous factors that have contributed to the increase in the DRS volume.

Public vs. Private

Many stakeholders were ambivalent about where the DRS should reside. The Ontario auto insurance system has undergone several major reforms over the past 23 years. Whether the DRS remained at FSCO, moved to a public sector tribunal or moved entirely to the private sector did not seem as important as ensuring that the new tribunal is staffed with adjudicators with knowledge and expertise on the current and earlier schemes. Adherence to prescribed timelines and accountability were also identified as important irrespective of where the system might reside.

However, I did notice a shift in positions following the release of the interim report. Some stakeholders who previously wanted the DRS to remain in its current form at FSCO are now in agreement that FSCO's adjudicative and regulatory functions should be separated. There is division on whether the DRS should remain at FSCO, become a public sector tribunal or become privatized.

I envision a public sector administrative tribunal to deal with SABS disputes, but not necessarily a new tribunal. SABS disputes might even be incorporated into an existing tribunal. Under the proposed model, the dispute resolution staff would no longer report to the Superintendent but to a responsible minister and arbitrators would be appointed by order-in-council.

I note that, in the last few years, the provincial government has transferred administrative responsibility for several adjudicative tribunals to the Ministry of the Attorney General (MAG). For example, clusters of tribunals in the following sectors have been created and transferred to MAG: Environment and Land; Social Justice; and Safety and Licensing Appeals.

¹ Bulletin A-02/11, Insurer Rights and Responsibilities to Challenge Questionable or Abusive Claims (March 22, 2011).

While policy responsibility remains with the expert ministry, this initiative promotes efficiencies and access to justice. It should be examined for suitability in relation to my recommendations regarding the DRS.

Under my proposed model, the new tribunal and the adjudicative staff would be better positioned to maintain their independence and neutrality while maintaining much of the existing expertise and experience. I believe the DRS requires considerable oversight and a public sector tribunal would be the best option for delivering the model described in this report. I see the tribunal primarily being funded by application fees, with the possibility of a portion of funding coming from insurance industry assessments.

Recommendation #1: A new DRS should be established as a public sector administrative tribunal reporting to the responsible minister.

Recommendation #2: Arbitrators should be appointed by order-in-council on the recommendation of the responsible minister.

As part of this review, U.S. jurisdictions with private arbitration systems were contacted. They indicated that they also experience backlogs and are not necessarily able to respond to changes in demand for services. I believe it may be incorrect simply to assume that the private sector will be more flexible. When designing a new delivery model, flexibility needs to be built in; it will not happen on its own. The contract between FSCO and ADR Chambers has successfully addressed the backlog of mediation cases. The new tribunal should make similar arrangements to ensure timely delivery of services and that it meets the recommended statutory timelines.

Recommendation #3: Tendered contracts should be established with one or more private-sector dispute resolution service providers to address fluctuations in demand for services.

Mandatory Mediation

As noted in the interim report, there was no clear consensus as to whether mediation should remain mandatory. However, there was strong support for merging mediation and pre-arbitration hearings and for introducing a more robust process as described in the interim report. I think everyone agrees that mediation resolves a large number of disputes expeditiously and at low cost. No one wants that taken from the system. Even in cases where mediation fails, it creates opportunities for future settlements and prepares the parties for arbitration. However, expanding the scope of mediation changes the dynamics. I am more comfortable referring to this process as a settlement meeting conducted by an arbitrator rather than a mediation.

Recommendation #4: Mediation services should be enhanced and continue to be a mandatory step in the DRS, but now as part of a settlement meeting.

The settlement meeting should take place within 45 days of an application being accepted by the tribunal's registrar. During the settlement meeting, a non-binding opinion on the likely outcome might be provided. If the settlement meeting does not conclude with a settlement of all issues in dispute, the parties should be prepared to disclose the evidence they will rely upon in support of their position at a hearing, since no pre-arbitration hearing will take place in the new model. This will also make the settlement meeting more meaningful than the current mediation process, since the parties will need to be completely familiar with their files in advance of the meeting. Needless to say, the company representative must have full authority to commit the insurer to a settlement.

A number of stakeholders indicated that it was important the arbitrators conducting the settlement meeting and arbitration be different individuals. It was suggested that discussions at the settlement meeting stage could prejudice a party in a future arbitration hearing, particularly where an opinion regarding the likely outcome of a future arbitration was expressed or settlement offers had been advanced.

Recommendation #5: The person conducting the settlement meeting should not also conduct the arbitration between the same parties.

Timeliness

Every stakeholder agreed that timeliness is an important principle in the DRS. The parties need to be able to access a system that can resolve disputes expeditiously. However, some believe that timeliness is no longer a problem for the DRS. They claim that since the mediation backlog has been eliminated, the pressure within the system has been eliminated and there is no longer a need to reform the system. I agree that eliminating the mediation backlog has addressed an immediate problem. However, FSCO statistics indicate there are more than 16,000 arbitration cases in the system and the number is growing. The backlog has simply been moved.

I also believe that the system needs to be able to adapt quickly to changes in demand for services. As I pointed out in my interim report, there are changes that will shorten the current timelines without impairing the ability of the system to provide parties with a just and fair outcome. Just because the existing DRS may be more timely than the courts, one should not conclude that the system cannot be improved.

It was noted there are many timelines already prescribed in the *Dispute Resolution Practice Code* that apply to both DRS users and dispute resolution staff at FSCO. Unfortunately, these timelines are not being applied in all cases. Setting out statutory timelines with penalties when they are not met without good cause appears to have broad support. In addition, most stakeholders were supportive of compressing the timelines as long as what is being proposed is realistic.

Recommendation #6: Statutory timelines and sanctions regarding settlement meetings, arbitration hearings and the release of arbitration decisions should be created.

A settlement meeting should be held within 45 days of an application being accepted by the registrar. Paper reviews should be held within 60 days of the receipt of a completed arbitration application following a failed settlement meeting. Similarly, arbitration hearings should be held within 90 days of the receipt of a completed arbitration application following a failed settlement meeting. Arbitration decisions should be issued within 30 days of a paper review and within 45 days of the completion of an in-person hearing. If either party is not ready to proceed within the statutory timeframes, they should not be eligible to claim their costs at the conclusion of arbitration.

In the event the tribunal does not have dates available for a settlement meeting or an arbitration hearing within the statutory timeframe, the registrar could reduce or waive the applicable fee. Similarly, if an arbitration decision is not issued within the statutory timeframe, the registrar should also be able to reduce or waive the arbitration fee. I understand that much of the cost of the proposed tribunal will be fully recovered from the insurance industry through fees and possible assessments. These sanctions provide some financial relief to the parties in a dispute where the process has been delayed.

Proportionality

Many stakeholders agreed with my suggestion that the system would be more efficient if disputes could be channelled into different streams based on the quantum of benefits in dispute or the complexity of issues involved. The interim report proposed a system with three separate streams for disputes. Following a settlement meeting where the issues in dispute have not been resolved, the case would then have either a paper review arbitration, an expedited in-person hearing or a full in-person hearing. The feedback I received suggests there is considerable support for paper reviews, although some have proposed alternative monetary thresholds, as well as additional criteria beyond a monetary threshold.

A significant number of groups indicated that paper reviews should not be assigned at the discretion of the adjudicator and should only be conducted when both parties have consented. Where there were issues regarding credibility or fraud, it was felt that oral testimony might be critical. Some opined that the type of claim in dispute is also a significant factor. For example, it was suggested that medical and rehabilitation disputes would be appropriate for a paper review, but income replacement disputes would not. Some were of the view that the \$25,000 threshold was too high.

There were also concerns expressed regarding the suggestion that the use of expert witnesses be restricted during expedited in-person hearings. Some felt that the length of hearings could be limited by introducing time limits. Some suggested that it should be left to the parties to decide how to use the time allotted to them, including whether to have an expert testify. I accept that restricting the length of a hearing will indirectly restrict the amount of expert testimony but provide the parties with the flexibility to decide how to use their experts. There were suggestions that a model similar to the *Rules of Civil Procedure* be adapted for the DRS, where experts certify their duty to the tribunal. I will return to these issues later in the report.

Accessibility

There was a clear consensus that the DRS remain accessible to claimants. I agree. Many insurers would like to see disincentives introduced to reduce the number of disputes being filed. As previously noted in this report, there is no consensus on the reason(s) for the sharp increase in mediation applications. Introducing disincentives might punish the wrong parties. Many stakeholders, including some insurers, recognize that introducing disincentives such as application fees for claimants could affect access to justice.

Recommendation #7: The policy of no application fees for claimants at the settlement meeting stage should be continued.

I think it is safe to say that no one supports parties on either side abusing the system. There are mechanisms already in place at the back end of the system to penalize those who abuse the process. However, some stakeholders would like to see sanctions used more frequently. I have reviewed the current regulation to be used by arbitrators in awarding costs and cannot suggest any amendment that would increase the use of sanctions, other than a requirement that the losing party always pay the costs of the winning party.² That would be unfair in a system where the resources of insurers greatly outweigh those of claimants. One proposal I heard would have the losing party pay the largest portion of the arbitration application fee should a hearing take place. Certainly, arbitrators should require a party to cover all or part of the other party's fees when it is found that the conduct of a party or a party's representative prolonged, obstructed or hindered the proceeding, or when any aspect of the proceeding was improper, vexatious or unnecessary.

Parties should also be penalized for not accepting a reasonable settlement offer. I envision this would work similarly to provisions under Rule 49 of the *Rules of Civil Procedure*. A claimant would not be eligible to claim costs if the arbitrator's decision orders the insurer to pay an amount that is less than the insurer's last settlement offer. An insurer would also not be able to claim costs if the arbitrator's decision orders the insurer to pay an amount that is more than the claimant's last settlement offer.³

² Section 12 of Ontario Regulation 664.

³ Subrule 49.10 under *Rules of Civil Procedure*, Ontario Regulation 194 under the *Courts of Justice Act*.

Recommendation #8: A claimant or insurer who abuses the process should be required to pay all or part of the settlement meeting and arbitration fees of the other party. A party should not be able to claim costs in arbitration if they refused a settlement offer that is more favourable than the amount ordered by the arbitrator.

There were strong opinions expressed as to whether claimants should continue to have the option of taking a dispute to court or the DRS arbitration system following a failed mediation.⁴ Proponents suggest that this option is a fundamental democratic right. However, there are many administrative tribunals where no such option exists. In addition, the option of a court proceeding runs contrary to the argument that it is important to maintain the knowledge and experience of the existing system. Everyone seemed to agree that the courts do not always possess the same expertise in interpreting the SABS as FSCO's arbitrators.

I am also concerned that some lawyers might find the shorter timelines and sanctions less appealing and, for that reason, choose to take cases to the courts instead of arbitration, if the option existed. During consultations, a number of lawyers suggested this was a real possibility. Including a court option would undermine the proposed reforms. In addition, I am reluctant to add to the already heavy caseloads in the courts.

I do not accept the argument that denying access to the courts would deny individuals access to justice. The proposed model outlined in the interim report would provide dispute resolution services that will be more timely and cost effective than the courts. No one suggested that parties have better outcomes respecting SABS disputes through the courts. The proposed model would provide excellent access to justice and I see no reason to continue providing the option to go to court in every case involving an application for statutory accident benefits. I also do not accept the argument that removing the court option would hinder settlement of an entire file — that is, both the accident benefit claim and the tort claim. A quicker DRS will ensure accident benefit disputes are resolved well before the tort claim is settled.

Recommendation #9: The option of initiating a court proceeding instead of arbitration should be eliminated when the parties are unable to reach a settlement.

⁴ Section 281 of the *Insurance Act* allows a claimant to choose between bringing a proceeding to court or referring issues in dispute to an arbitrator following failed mediation.

Predictability

I would agree with those who pointed out that the principle of predictability is undermined by the cyclical pattern of reforms to the system aimed at controlling or stabilizing costs. Each set of reforms introduces new benefit qualifications, thresholds, caps and tests that add uncertainty. I have been told that many previous reforms have been ineffective in stabilizing costs and have contributed to the complexity of the system.

In addition, the SABS has become a complex and difficult document to interpret; many stakeholders noted that it is very difficult to work with it. Insurance companies need to make a considerable investment in training and developing adjusters, as does FSCO in respect to its mediators and arbitrators. Claimants need to find representatives well versed in the regulations. The learning curve associated with the SABS adds cost to the system. Other no-fault schedules are far less complex and not so procedure-oriented. Everyone would benefit from a wholesale review of the SABS in an effort to simplify the regulation. As I have mentioned previously, the DRS is but one component of the Ontario auto insurance system. However, these other issues are beyond the scope of my review.

I accept the notion that certainty and predictability are important to insurers in order to properly set reserves, purchase reinsurance and charge premiums, which are reflective of risk. This is also important to claimants, as it helps them know what their auto insurance coverage provides. However, increased certainty and predictability can also lead to higher costs if full and final settlements exceed the future needs of claimants. I'm not sure the public is prepared to pay more for auto insurance in order to have a more predictive product.

There was a debate among stakeholders regarding the publishing of arbitration decisions. There was no compelling argument presented for removing transparency from the system. I believe publishing arbitration decisions makes the DRS more accountable and creates public confidence in the system. Although publishing arbitration decisions does not necessarily make the system more predictive, it does inform users how their issues might be dealt with within the system.

Recommendation #10: Arbitration decisions should continue to be published.

As well, there was some confusion regarding a statement in the interim report suggesting that arbitration decisions would only apply to that individual case. My intent was that arbitration decisions would not be binding on other disputes. However, it is important that similar fact cases should have similar outcomes. For this reason, publicly releasing decisions is necessary.

The purpose of the DRS is to resolve disputes with respect to the SABS and not create case law. I believe it is contrary to the intent of the DRS to have decisions set precedents, although the decisions will inform stakeholders as to how the SABS might be interpreted.

Recommendation #11: An arbitration decision should provide guidance but not be binding on other disputes.

In the interim report, I reviewed a proposal from the Insurance Bureau of Canada (IBC) that would provide arbitrators with access to independent medical consultants who would provide opinions on benchmarks for generally-expected treatment and recovery times. The proposal had little support. In fact, a number of companies were not in agreement. Stakeholders were concerned that additional medical opinions would add cost to the system, extend timelines and lead to issues regarding quality control. The proposal, in my view, would be contrary to the principles of a streamlined and timely system.

Stakeholders strongly supported the current system in which parties provide their own experts. Based on the DAC experience, maintaining a roster of independent medical consultants would require significant oversight and would likely be contentious. I am reluctant to support the creation of more bureaucracy in what is already a complex system.

Scientific evidence is often not an issue in arbitrations. More often, there are credibility issues with respect to the nature and extent of the injuries. There is no guarantee that those on an independent medical consultant roster would be current on medical and scientific research. FSCO has a contract with the University of Ontario Institute of Technology to conduct research on the treatment of minor injuries and make recommendations regarding a treatment protocol. I believe unambiguous evidence-based guidelines will likely be more helpful to arbitrators than a roster of medical consultants.

The insurance industry has advocated for the use of rule-making as authorized by sections 268.2 and 121 (1) paragraph 10.2 of the *Insurance Act*. Those provisions allow for the Lieutenant Governor in Council to make regulations prescribing rules for interpreting the SABS. I am not sure what the drafters had in mind, but releasing a regulation prescribing rules for interpreting another regulation would likely add additional complexity to an already overburdened system. If the SABS needs clarification, then the government should just amend that regulation.

However, I did not find the industry's desire to mirror the workplace insurance system necessarily feasible. Without question, there are some elements of the WSIB that could be adopted by the Ontario auto insurance system. However, there are limitations dictated by a different statutory scheme and the fact that the WSIB is a government-run insurer. The creation of a set of rules similar to the WSIB's Operational Policy Manual does not commend itself to me. The manual is an internal document for WSIB adjudicative staff authorized by the *Workplace Insurance and Safety Act*.⁵

FSCO's Superintendent is limited by statute to issuing guidelines, which are only binding if incorporated by reference into the SABS. For example, the SABS authorize the Superintendent to publish a Minor Injury Guideline and a Professional Services Guideline.

FSCO's arbitrators have been criticized by the insurance industry for making policy. I agree that one does not want arbitrators making policy, but they certainly are required to interpret and apply policy. There is no universally accepted view as to when arbitrators cross that line. The appeal process is intended to address these situations. During my initial consultations with stakeholders in September 2013, every insurer commented on how the then-recent *Scarlett and Belair Insurance* decision illustrated how "broken" the system was.⁶ The *Belair* case was the first arbitration case to consider what injuries are not included in the SABS definition of "minor injury." During the December 2013 consultations, the case was no longer raised because a decision by a Director's Delegate had addressed the industry's concerns, overturning the arbitrator's decision.^{7 8}

⁵ Section 159 (2) of the *Workplace Safety and Insurance Act*.

⁶ *Scarlett and Belair Insurance*, FSCO A12-001079 (March 26, 2013).

⁷ *Scarlett and Belair Insurance*, Appeal P13-00014 (November 28, 2013).

⁸ The claimant filed for Judicial Review on January 13, 2014.

Another case raised during the initial consultations was a Superior Court decision, *Henry v. Gore Mutual*, which was upheld by the Ontario Court of Appeal.^{9 10} This case dealt with the SABS definition of “incurred expense,” which was introduced as part of the 2010 auto insurance reforms. The concerns raised by the industry regarding *Henry v. Gore Mutual* also disappeared in December 2013, when the government released regulatory changes that reversed the Superior Court and Appeal Court decisions.¹¹ This suggests to me that the checks and balances in the present system can work. Parties have the right to appeal decisions and the government can clarify or change policy through regulation. The SABS can be amended to incorporate new guidelines to address any rule-making needs within the auto insurance system.

Recommendation #12: The government should continue to use binding Superintendent’s Guidelines incorporated by reference into the SABS to provide stakeholders and adjudicators with direction as required.

Streamlining

There was strong support for merging mediation and pre-arbitration hearings and doing away with neutral evaluation in order to streamline the system and shorten timelines. Presently, neutral evaluation is a step available before arbitration, where an experienced evaluator can assess the issues in dispute and give a non-binding opinion about the likely outcome of the case should it go on to arbitration. However, the last time the process was used at FSCO was in 2008, so eliminating it makes sense. I propose that instead of mediation, a settlement meeting be conducted where an arbitrator will not only mediate between the parties but, in some cases, provide a non-binding opinion about the likely outcome of an arbitration. In addition, the parties should also be required to disclose the evidence they plan to rely on in support of their position at an arbitration. This potentially evaluative process will be more robust and allow adjudicators to be more engaged.

If, as I suggest, the arbitration takes place shortly after a settlement meeting and the parties have already resolved jurisdictional issues, exchanged appropriate documents and made full disclosure, then no additional meetings would be necessary.

⁹ *Henry v. Gore Mutual Insurance Company*, 2012 ONSC 3687.

¹⁰ *Henry v. Gore Mutual Insurance Company*, 2013 ONCA 480.

¹¹ Subsections 18 (2) and 19 (3) of the *Statutory Accident Benefits Schedule – Effective September 1, 2010*, Ontario Regulation 34/10 as amended by Ontario Regulation 347/13.

I received some comments about the current two-year limitation period for applying for mediation. Allowing a claimant two years following a denial of benefits does seem excessive in light of the fact that I am looking at streamlining the dispute resolution process. However, I am also cognizant of the fact that unrepresented claimants may not be fully aware of their right to dispute a denial. Consequently, I am not proposing to change the limitation period at this time.

Recommendation #13: The current pre-arbitration meetings and neutral evaluation should be combined into a new settlement meeting.

For practical reasons, nearly all mediations are currently conducted through telephone conference calls. Some in the insurance industry were critical of my suggestion that in-person mediations are not always practical and that new technologies, such as video conferencing, should be adopted. I was not suggesting that claimants should not participate in the process. FSCO mediation staff agrees that the process is more likely to be successful if the claimant is participating and is able to hear what an insurer is saying without being filtered through a representative. Adopting video conferencing through platforms such as Skype makes sense now that the technology is readily available and inexpensive. Video conferencing would facilitate a more engaged claimant, which will become important under a system with shorter timelines. Unrepresented claimants without access to the technology should be encouraged to participate in settlement meetings in person. FSCO is located in Toronto and service delivery is largely centralized in Toronto. For a more participatory process, either service delivery should become more decentralized or adjudicators make better use of technology.

As we are beginning to realize, online mediation is developing at a significant pace. I believe it may very well become the norm, particularly in smaller disputes.

Recommendation #14: Settlement meetings should be conducted by video conferencing rather than by telephone in cases where it is not feasible for the parties to meet in person.

In the interim report, I reflected on the possibility of allowing health care providers to dispute treatment plan denials. My concern was that health care providers might be in the best position to defend a claimant's treatment needs. In most cases, medical and rehabilitation benefits are paid directly to providers. Although the proposal was not included in the framework set out in the interim report, it received a considerable feedback — all of it negative.

I accept the argument presented by many that the core of disputes usually requires the direct involvement and participation of claimants. A health care provider may not be fully aware of past medical history or concurrent treatment being provided. As well, removing the claimant from the process could expose the system to a greater risk of fraud. In addition, it is important that claimants be aware of how their benefits are being used. Without their participation, claimant awareness would likely diminish.

Health care providers also did not support my proposal that they be required to defend their treatment recommendations in the DRS. However, they would like to access the system for collection purposes. I do not see that as an appropriate use of DRS resources. There are other mechanisms available for collecting overdue accounts.

Finally, there were suggestions that an electronic filing system be developed to streamline the application process. I agree with that suggestion. This should be considered by the new tribunal.

Costs

I recognize there is a significant imbalance in terms of resources and familiarity with the system between claimants and insurers. It has been pointed out to me that in the early days of no-fault insurance, when a benefit denial was disputed, benefits would continue to be paid in certain circumstances pending the resolution of the dispute. Those provisions were removed from the SABS long ago. If disincentives are needed, they should be directed at those who abuse the system rather than affecting the majority of claimants.

There was clearly a significant split between the insurance industry and the plaintiff bar with respect to issues of application fees and costs. Some stakeholders pointed out that the DRS is less generous in reimbursing costs than the courts. The cost of expert reports is capped and the allowable hourly rates awarded to counsel are lower than the courts.

If there was any consensus, it was that the system should be cost-efficient and that graduated fees would be both fair and appropriate. Stakeholders supported a series of fees based on how far the dispute advanced through the system. For example, there would be an established fee for a settlement meeting. If, however, a settlement is reached after entering the system but before the settlement meeting, then only a partial fee should be collected. Similarly, if the parties settle after an arbitration date has been set but before the arbitration takes place, then again only a partial fee would be collected.

Recommendation #15: Fees should be established for settlement meetings and the different streams of arbitration. Settlement meeting and arbitration fees should be reduced where the parties settle in advance.

During my consultations, the subject of adjournments often came up. Adjournments delay adjudication and a number of stakeholders felt that adjudicators should resist requests for them. It was also suggested that a fee could be paid by the party or parties seeking an adjournment. The tribunal should be committed to an early resolution of disputes. Therefore, it should be the policy of the tribunal that adjournments be strongly discouraged and only granted in the most extenuating circumstances. When they are granted, the requesting party should pay a fee unless there are exceptional reasons.

Recommendation #16: An adjournment fee should be established, which could be charged to the party requesting an adjournment in the absence of exceptional circumstances.

Culture

There was no consensus on the proposal to extend the current one-year prohibition on settlements on a full and final basis. However, I was encouraged that a number of insurers acknowledged that the current practice was counterproductive and that they would support extending the prohibition. This issue is partially tied to the ten-year period in which a claimant may claim medical and rehabilitation benefits. If that timeframe were to be shortened, as insurers have suggested, it appears more insurers would support extending the prohibition on settlements. However, benefit entitlement issues are outside the scope of this review.

Some insurers expressed concerns about a permanent ban on settlements. The health and life insurance industry does not provide lump sum settlements and will continue to adjust benefit applications on an ongoing basis. Auto insurers have indicated that keeping files open for years increases administrative costs. I understand that property and casualty insurers have a different mindset than disability insurers. However, it makes more sense to manage accident benefit claims in the same manner as disability claims, not property damage claims. I accept that auto insurance contracts and disability insurance contracts are quite different. The complexity of the SABS makes claims handling a challenge. Disability insurance contracts contain far fewer procedures and are not regulated products. As a result, the cost of handling accident benefit files is much higher.

Accident victims also expressed a similar concern, but from a different perspective. Although some found their insurer very supportive following an accident, others found themselves very quickly in an adversarial relationship. A full and final settlement allows claimants to sever the relationship with their insurers and move on with their lives.

Where the injuries are catastrophic, a full and final settlement seems to make sense for both sides. It provides an insurer with cost certainty, while providing a claimant with the ability to plan for the future properly without concern that benefits might later be denied.

I am supportive of a compromise between those who would like to see a longer prohibition on settlements and those who support the status quo. I propose a two-year restriction on lump sum settlements of future medical and rehabilitation benefits. This would ensure that medical and rehabilitation benefit payments are used for health care goods and services.

Recommendation #17: The settlement of future medical and rehabilitation benefits should be prohibited until two years after the date of the accident.

For the most part, the insurance industry was silent on the impact of high caseloads on the system. I believe some companies need to take a hard look at the level and quality of service being provided. A number of stakeholders suggested that insurers who do not adequately explain the reasons for denials seem to invite disputes. I have no way to confirm whether this is true or whether inadequate feedback to claimants is related to adjusters having unusually high caseloads.

Insurer Examinations

Insurer examinations (IEs) under section 44 of the SABS were not part of the mandate of this review. Nevertheless, many stakeholders felt it was important to provide comments on insurers' use of independent medical assessments. These medical assessments are not unique to Ontario's auto insurance system. They are used by almost every other insurance program, as well as by workers' compensation systems and employers.

An independent medical examination occurs when a health care provider who has not previously been involved in a person's care examines the individual. Since there is no established doctor/therapist-patient relationship, insurers rely on them and claimants may disavow them. These assessors may be independent of the claimant, but they are not necessarily independent of the insurer. Perhaps that is why the drafters of the SABS decided to refer to these assessments as insurer examinations rather than independent medical examinations.

IE assessors are regulated by the assessor's health regulatory college, which requires objectivity and impartiality. However, objectivity and impartiality are difficult to evaluate. I have been told by consumer advocates that the health regulatory colleges have not been responsive to complaints regarding members who conduct IEs. IE assessors working in the auto insurance system have no standard assessment protocols, report formats or timelines, and I imagine it must be a challenge to insulate themselves from outside influence.

I received numerous submissions about IEs, including a suggestion that I look at the Colorado Personal Injury Protection Examination Program, which regulates the use of independent medical examinations. The Automobile Insurance Anti-Fraud Task Force recommended that the government license treatment and assessment facilities operating in the Ontario auto insurance system.¹² I understand FSCO has been working with stakeholders on such a system. However, the Task Force recommendation only covers the business practices of IE assessors. I expect it will fall short of the expectations of the critics. In addition, in the 2009 five-year review of automobile insurance, the Superintendent recommended that health care professional associations and the insurance industry jointly develop standards for the delivery of third-party medical examinations, as well as qualifications for assessors.¹³ I understand that this recommendation has not been implemented to date.

¹² Recommendation #13, Final Report of the Automobile Insurance Anti-Fraud Task Force (November 2012).

¹³ Recommendation #16, Report on the Five-Year Review of Automobile Insurance (March 31, 2009).

The reason stakeholders have raised issues regarding IE assessors is that their reports and testimony are often used by insurers in the DRS to support benefit denials. Just as the treating health care provider often acts as an advocate for the claimant, the IE assessor is selected because he or she might support the insurer's position. As previously noted, there was a suggestion that each expert be required to certify his or her duty to the DRS to provide fair, objective and non-partisan evidence with a certificate similar to that under the *Rules of Civil Procedure*.¹⁴

Part of the culture shift that I see being needed within the DRS is that medical experts appearing before adjudicators should have a duty to the DRS and not to the party that has retained them. The problem is obvious. An expert retained by an insurer who supports claimants is unlikely to be retained again. For this culture shift to be successful, the government will need to be proactive. The government will need to reach out to health professional associations and the insurance industry in order to educate experts on their duty to provide fair, objective and non-partisan evidence. In addition, I would like to see arbitrators ignore evidence that is not considered fair, objective and non-partisan and, in such instances, the expert should not receive compensation for appearing as a witness.

Recommendation #18: Experts should be required to certify their duty to the tribunal and to provide fair, objective and non-partisan evidence. Arbitrators should ignore evidence that is not fair, objective or non-partisan and, in such instances, the expert should not receive compensation for appearing as a witness.

¹⁴ Subrule 53.03 under *Rules of Civil Procedure*, Ontario Regulation 194 under the *Courts of Justice Act*.

Feedback on the Proposed Framework

Timeframes

There was wide-spread support for a process that would take no more than six months, with some reservations. Some were concerned about availability of counsel and whether all the issues in a claim would have materialized in that time frame. Certainly, there will be challenges for parties in transitioning to a shorter and more streamlined system. It was suggested that some complex cases, such as the determination of catastrophic impairment, might require up to nine months to resolve. I will set out recommended timelines later in the report.

Internal Review

Not all insurers agreed that an internal company review process should be introduced. Some were concerned that this would extend the process rather than streamline it. Many claimed that their company already had a review process. However, not all existing internal processes are transparent to the claimant. Other insurers were quite supportive of this process if it provided them with direct access to claimants.

Many stakeholders suggested that, should an internal company review process be introduced, it should be claimant-initiated rather than automatic on every denial. I do not want to see this process extend timelines. Nor do I believe the internal review process should be a mandatory step before filing a settlement meeting application. I see this process operating similarly to the company's complaint officer protocol. I view it as an additional tool to assist parties facilitating early resolution of a dispute. As well, I cannot see why insurers would not want to take this extra step to retain their customers.

Recommendation #19: Each insurer should establish an internal review process and be required to inform a claimant how to access it following a benefit denial.

With respect to how the internal review should be conducted, there was no consensus. Feedback suggested paper reviews, telephone interventions and in-person meetings. I do not want this to become a labour-intensive step, and therefore suggest that the process be a paper review. That would not preclude the parties from also communicating over the phone or in person. Most stakeholders would support a simple, non-bureaucratic process. Only a small number of stakeholders proposed a regulated process with standard forms. What seems to make most sense to me is a requirement that each insurer inform claimants of the existence of an internal review process and make it available to those who request it. The review should be conducted by someone other than the adjuster on the file. A company ADR Coordinator would be an appropriate person. What is most important is that the company representative have the authority to commit the insurer to a settlement. The one stipulation I propose is that the insurer respond in writing within 30 days.

Recommendation #20: Each insurer will determine how their internal review process is to be structured, but must provide a claimant with a written response that includes the outcome of the review and reasons for the company's decision within 30 days of the claimant's request.

There was some concern expressed that this process could be subject to abuse, where insurers are receiving multiple requests from the same claimant. Therefore, if adopted, the process would need to be monitored, reviewed and adjusted, if necessary. The auto insurance system does not need more layers of ineffective process so an early review of the proposed process should be conducted by the responsible ministry.

Recommendation #21: The Superintendent should collect utilization statistics from each insurer. A review should be conducted within two years to determine whether the internal review process leads to fewer disputes.

Gatekeeper

Most groups support the gatekeeper role set out in the interim report, but feedback suggests this will be a challenging function. For example, parties often do not always agree on whether a request for an IE was communicated in accordance with the SABS. Under the current system, it is not uncommon to have a preliminary hearing by an arbitrator to determine whether the IE request is appropriate. This hearing usually takes place well after the mediation application is filed. I believe it is best for the parties to have these type of issues addressed at the start of the process. Therefore, I am proposing a registrar position be established at the tribunal to review applications and deal with outstanding issues.

Similarly, issues regarding production need to be addressed early on. Where the registrar is able to direct the parties on these issues, it will lead to much earlier resolution of disputes. I understand that some documents, such as hospital records, can take months to access. Therefore, it will be necessary to ensure that the system is flexible enough to recognize and accommodate delays that are not caused by the parties to a dispute. As well, the extent of production needs to be proportional to the issues in dispute. Timely and proportionate disclosure would increase the opportunity for early settlements. Excessive disclosure requests can have the opposite effect.

I would further suggest that the registrar or an arbitrator have the authority to consolidate applications involving the same claimant and insurer. This would make the system more cost-efficient and effective. Multiple applications involving the same claimant and insurer have the potential to clog the system with small disputes.

Recommendation #22: Settlement meeting applications should be reviewed by the tribunal's registrar, who will determine if the parties are ready to proceed to a settlement meeting. The application should only be accepted once all outstanding issues have been addressed. The registrar or an arbitrator should be able to consolidate applications involving the same claimant and insurer.

The registrar will need to be very familiar with the SABS. This will require contact with both parties and representatives to confirm the parties are prepared to proceed with a settlement meeting. In some cases, the registrar will be required to make a determination as to whether the parties have complied with the regulations. A decision by the registrar should be final and not subject to appeal.

Other suggestions regarding the gatekeeper function included a requirement that claimants notify insurers of their intention to file an application, the acceptance of only complete applications and an electronic filing system to streamline the application and registration processes. I support the development of an electronic filing system.

Insurers are currently able to log into the Dispute Resolution Case Directory to determine how many mediation applications have been entered into the system by FSCO. When an electronic filing system is developed, I would hope that the system have the ability to inform an insurer automatically when an application is filed.

Recommendation #23: The tribunal should develop an electronic filing system to expedite the filing of settlement meeting and arbitration applications.

Triage

Stakeholders generally supported the proposed triage process, where disputes would be divided into different streams. Some commented that the quantum of benefits in dispute ought not be the sole criteria used to determine the stream. There were a number of suggestions regarding factors that might be considered by an arbitrator when triaging a dispute, including:

- the quantum of benefits in dispute (including future value of benefits);
- whether the credibility of parties involved in the dispute needs to be determined;
- whether the dispute primarily involves statutory interpretation;
- whether the dispute primarily involves treatment issues;
- whether the dispute involves opposing medical views;
- the number of issues in dispute; and
- the complexity of the case.

Stakeholders were divided as to who should ultimately determine the stream into which a case would fall. Some were of the opinion that the decision should ultimately rest with the arbitrator, while others thought that the parties needed to consent. I believe the arbitrator would want input from the parties on why they think the dispute should fall into a particular stream. This process should be informal and not create the need for a hearing. A decision by an arbitrator in this respect should be final and not subject to appeal.

Recommendation #24: Following an unsuccessful settlement meeting and the filing of an arbitration application, the arbitrator should inform the parties whether it will take the form of a paper review, an expedited in-person hearing or a full in-person hearing.

Paper Reviews

While there was strong support for an expedited process that included paper reviews, there was no agreement as to which disputes should be subject to paper reviews. I am proposing that the threshold be set at disputes regarding medical and rehabilitation benefits under \$10,000 and involving minor injury determinations. At some point, with the introduction of a minor injury treatment protocol, these determinations will likely become perfunctory.

Recommendation #25: Arbitration hearings should be conducted as paper reviews in cases where there are \$10,000 or less of medical and rehabilitation benefits in dispute, or where the dispute involves a determination as to whether the claimant's injuries meet the minor injury definition.

A paper review would take place within 60 days following the receipt of a completed application. The parties would provide documentation in support of their position prior to the hearing. The arbitrator should be required to provide the parties with a written decision within 30 days of the date of the review. The tribunal should introduce restrictions on the length of expert reports and briefs. The arbitrator's report should be no longer than three pages in length.

Expedited Hearings

The interim report provided a description of an expedited hearing process for straightforward disputes considered to be inappropriate for a paper review. Concerns were expressed regarding my proposal to introduce restrictions on reports. Some felt that shorter reports would deprive arbitrators of complete medical opinion evidence. The intent of my proposal was not to restrict content as much as to force the authors of reports to be more concise. I still believe that the new tribunal should take a tough position and limit the length of expert reports and legal briefs. This is part of the culture shift that needs to occur.

There were similar concerns expressed about limiting the number of witnesses. Some suggested that restricting the ability to cross-examine experts may shift adjudication to health care providers because arbitrators would more likely have to rely solely on a medical report. Several stakeholders suggested that a simpler, more flexible approach would be to have the adjudicator allocate time to each side and let the parties decide how to make use of it. Another suggestion was that a model similar to the Simplified Procedures under the *Rules of Civil Procedure* be adopted for expedited hearings.¹⁵

I also heard from others who thought there was no need to create an expedited in-person hearing process because the number of hearings conducted each year remains relatively small. Recommendations in this regard, however, are part of an overall package of suggested reforms that, taken together, should address the backlog and promote greater confidence in the DRS.

Recommendation #26: Arbitration hearings should be conducted as an expedited in-person hearing in cases that do not qualify as either a paper review or full in-person hearing. This determination should be made by an arbitrator and not subject to appeal.

All in-person hearings should take place within 90 days following the receipt of a completed application. An expedited in-person hearing would last no longer than one day and the arbitrator would inform parties as to how much time would be allocated for them to present their cases. The arbitrator should be required to provide parties with a written decision within 45 days of the hearing date. The tribunal should introduce restrictions on the length of expert reports and briefs. The arbitrator's report should be no longer than five pages.

Full Hearings

Various groups provided suggestions regarding the types of claims that should have access to full in-person hearings. These included catastrophic determinations, income replacement beyond 104 weeks and 24-hour attendant care claims. There was a consensus that time limits on full hearings are not necessary because there will be so few of them. Stakeholders were very supportive, however, of enforced timeframes on the release of arbitration decisions.

¹⁵ Rule 76 under *Rules of Civil Procedures*, Ontario Regulation 194 under the *Courts of Justice Act*.

Recommendation #27: Arbitration hearings should be conducted as full in-person hearings for disputes involving catastrophic impairment determinations and whether the claimant qualifies for 24-hour attendant care or income replacement benefits beyond 104 weeks.

All in-person hearings should take place within 90 days following the receipt of a completed application. The length of a full in-person hearing would be determined by the arbitrator, who would also have the ability to set time limits. Prior to determining the length of a hearing, each case will require some rigorous case management to narrow issues and provide accurate time estimates. The arbitrator should be required to provide the parties with a written decision within 45 days of the completion of the hearing. Again, there should be restrictions on the length of expert reports and briefs, and the arbitrator's report should be no longer than ten pages.

Appeals

The stakeholder community was divided on this issue. In my interim report, I suggested that a single judge of the Superior Court hear appeals. Those opposed were concerned that Superior Court judges are not always familiar with the SABS. They would prefer to continue using the Director's Delegate as a means of challenging an arbitration decision. I strongly support the use of the court to deal with these appeals to ensure they are dealt with properly and consistently. Because the SABS are highly complex, it might be helpful if certain judges with experience in the area were assigned, much like the Commercial List. The volume of possible appeals will not pose a problem for the court.

Recommendation #28: Appeals of arbitration hearing decisions should be heard by a single judge of the Ontario Superior Court of Justice on a question of law.

Fast-Tracking Issues

There were few comments on the proposal to fast-track issues through the DRS and the courts. Under the proposed reforms, disputes will be resolved much more quickly and the need to fast-track cases will likely diminish.

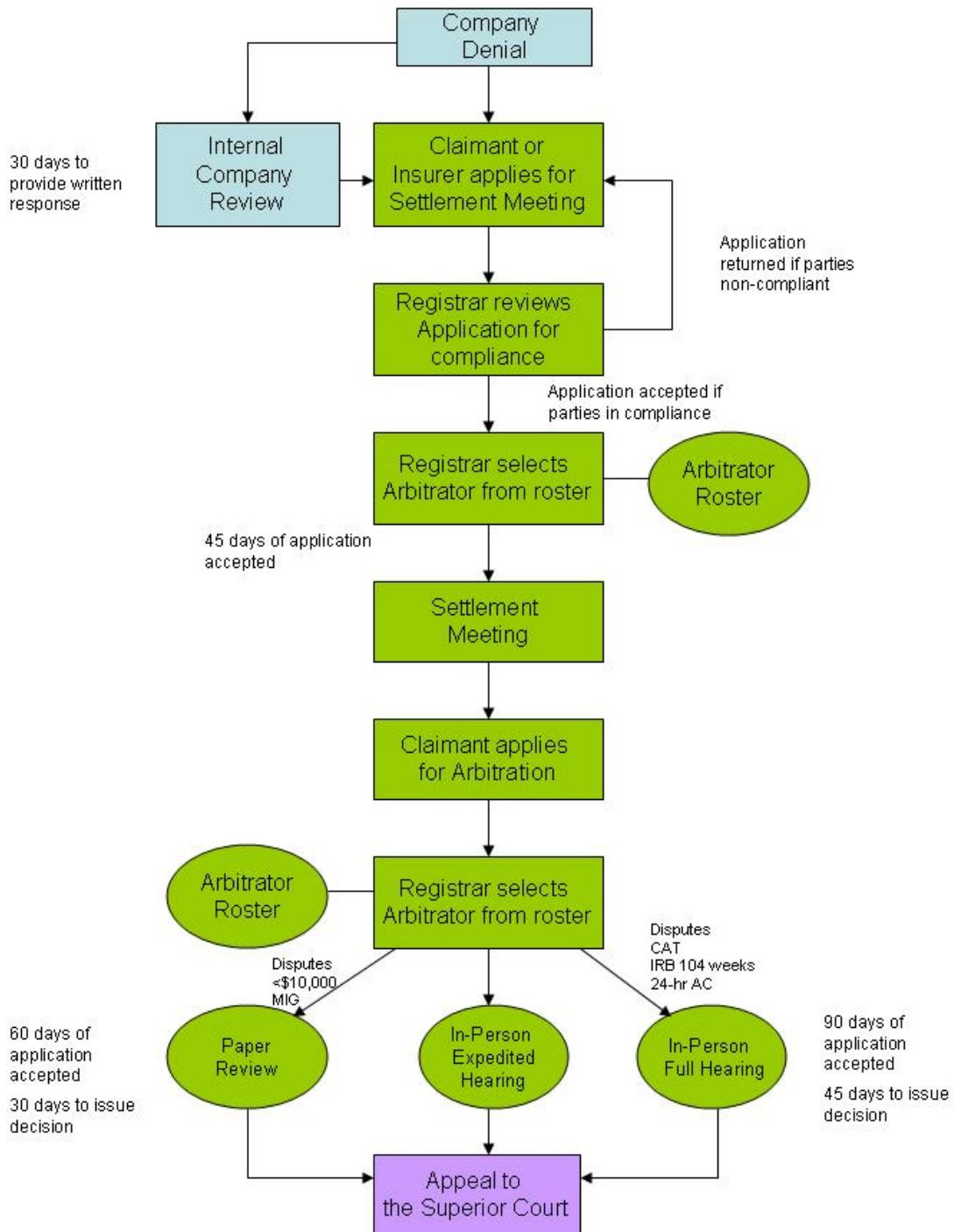
Appendix A – List of Recommendations

- 1.** A new DRS should be established as a public sector administrative tribunal reporting to the responsible minister.
- 2.** Arbitrators should be appointed by order-in-council on the recommendation of the responsible minister.
- 3.** Tendered contracts should be established with one or more private-sector dispute resolution service providers to address fluctuations in demand for services.
- 4.** Mediation services should be enhanced and continue to be a mandatory step in the DRS, but now as part of a settlement meeting.
- 5.** The person conducting the settlement meeting should not also conduct the arbitration between the same parties.
- 6.** Statutory timelines and sanctions regarding settlement meetings, arbitration hearings and the release of arbitration decisions should be created.
- 7.** The policy of no application fees for claimants at the settlement meeting stage should be continued.
- 8.** A claimant or insurer who abuses the process should be required to pay all or part of the settlement meeting and arbitration fees of the other party. A party should not be able to claim costs in arbitration if they refused a settlement offer that is more favourable than the amount ordered by the arbitrator.
- 9.** The option of initiating a court proceeding instead of arbitration should be eliminated when the parties are unable to reach a settlement.
- 10.** Arbitration decisions should continue to be published.
- 11.** An arbitration decision should provide guidance but not be binding on other disputes.
- 12.** The government should continue to use binding Superintendent's Guidelines incorporated by reference into the SABS to provide stakeholders and adjudicators with direction as required.
- 13.** The current pre-arbitration meetings and neutral evaluation should be combined into a new settlement meeting.

- 14.** Settlement meetings should be conducted by video conferencing rather than by telephone in cases where it is not feasible for the parties to meet in person.
- 15.** Fees should be established for settlement meetings and the different streams of arbitration. Settlement meeting and arbitration fees should be reduced where the parties settle in advance.
- 16.** An adjournment fee should be established, which could be charged to the party requesting an adjournment in the absence of exceptional circumstances.
- 17.** The settlement of future medical and rehabilitation benefits should be prohibited until two years after the date of the accident.
- 18.** Experts should be required to certify their duty to the tribunal and to provide fair, objective and non-partisan evidence. Arbitrators should ignore evidence that is not fair, objective or non-partisan and, in such instances, the expert should not receive compensation for appearing as a witness.
- 19.** Each insurer should establish an internal review process and be required to inform a claimant how to access it following a benefit denial.
- 20.** Each insurer will determine how their internal review process is to be structured, but must provide a claimant with a written response that includes the outcome of the review and reasons for the company's decision within 30 days of the claimant's request.
- 21.** The Superintendent should collect utilization statistics from each insurer. A review should be conducted within two years to determine whether the internal review process leads to fewer disputes.
- 22.** Settlement meeting applications should be reviewed by the tribunal's registrar, who will determine if the parties are ready to proceed to a settlement meeting. The application should only be accepted once all outstanding issues have been addressed. The registrar or an arbitrator should be able to consolidate applications involving the same claimant and insurer.
- 23.** The tribunal should develop an electronic filing system to expedite the filing of settlement meeting and arbitration applications.
- 24.** Following an unsuccessful settlement meeting and the filing of an arbitration application, the arbitrator should inform the parties whether it will take the form of a paper review, an expedited in-person hearing or a full in-person hearing.

- 25.** Arbitration hearings should be conducted as paper reviews in cases where there are \$10,000 or less of medical and rehabilitation benefits in dispute, or where the dispute involves a determination as to whether the claimant's injuries meet the minor injury definition.
- 26.** Arbitration hearings should be conducted as an expedited in-person hearing in cases that do not qualify as either a paper review or full in-person hearing. This determination should be made by an arbitrator and not subject to appeal.
- 27.** Arbitration hearings should be conducted as full in-person hearings for disputes involving catastrophic impairment determinations and whether the claimant still qualifies for 24-hour attendant care or income replacement benefits beyond 104 weeks.
- 28.** Appeals of arbitration hearing decisions should be heard by a single judge of the Ontario Superior Court of Justice on a question of law.

Appendix B – New DRS Model



Appendix C – List of Stakeholder Submissions

The Advocates' Society

Allstate Insurance Company of Canada

Association of Independent Assessment Centres

Association of Management, Administrative and Professional Crown Employees of
Ontario

Aviva Canada

Viraf Baliwalla

Dr. Harold Becker

Canadian Association of Direct Relationship Insurers

Canadian Centre of Excellence in Injury Law

Canadian Society of Chiropractic Evaluators

The Co-operators Group Limited

County and District Law Presidents' Association

Desjardins General Insurance Group

Julie Entwistle

FAIR Association of Victims for Accident Insurance Reform

FSCO's Arbitrators

FSCO's Mediators

Economical Mutual Insurance

inHEALTH

Insurance Brokers Association of Ontario

Insurance Bureau of Canada

Intact Financial Corporation

Kahler Personal Injury Law

Medico-Legal Society of Toronto

Ontario Bar Association

Ontario Mutual Insurance Association

Ontario Psychological Association

Ontario Rehab Alliance

Ontario Trial Lawyers Association

State Farm Mutual Automobile Insurance Company

Taylor, Steinberg & Baber

TD Insurance

Zarek Taylor Grossman Hanrahan