SUBMISSIONS ON BEHALF OF THE BAR DISPUTE FORUM GROUP AT THE FINANCIAL SERVICES COMMISSION OF ONTARIO

The Bar Dispute Forum Group (BDFG) is comprised of lawyers that represent parties involved in mediation and arbitration proceedings concerning entitlements to Statutory Accident Benefits (SABS). Meetings are held 5 times per year with the Director of Arbitrations and staff from the Dispute Resolution Group to discuss concerns with respect to procedural and substantive issues in order to try to improve the system. It has been in existence since 1991 following implementation of the OMPP regime.

Participants in the BDFG include senior counsel that have practiced under all three SABS regimes, have published and lectured in the legal field with respect to accident benefits, been members of Committees involved in drafting previous legislation and have made valuable contributions in the development of practice and procedure in this area both at the Financial Services Commission of Ontario and in the Ontario Court system.

The members of the BDFG who have contributed to the issues raised for consideration in this submission are as follows:

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The above group represents the interests of both victims and insurers. The issues raised below are intended to alert the 5 year review process to areas where the BDFG believes a closer examination should be made. Some of the issues are oriented more to insurer concerns, and others to victim concerns. All are put forward to assist in moving the system towards both fairness and certainty.

The following issues are presented in no particular order.

1. Catastrophic Impairment

The current edition of the SABS mandates usage of the AMA guides 4th ed. The 4th edition itself indicates at ss.1.5 “the AMA strongly discourages the use of any but the most recent edition of the guides, because information in it would be based on the most recent and up to date materials”

The 4th edition was first published in 1993 and has been out of print for almost a decade. The 6th edition was published in December, 2007 and is the most current edition.

Rather than continue to mandate use of outdated materials, or switch references to a specific guide at all, a simple solution is to reference the “current edition” of the guides at the time of consideration of the issue of catastrophic.

It makes little sense to mandate usage of outdated materials.

2. Infant victims lost in Bill 164 transition provisions

Section 20 of the most recent amendments to the transitions provisions must be amended to allow access to LEC offer process and assessment process for individuals who were students and/or under the age of 16 at the time the accident occurred and

who would not as yet entered a litigious process due to their age. This is an issue that both Applicant's and Insurer's Counsel recognize must be immediately corrected.

3. Eliminating paper reviews of OCF 22 Requests for Assessments

OCF 22 assessments were introduced in the Bill 198 amendments. Requests are made by applicants utilizing the OCF 22 form for approval for assessments by various types of health care practitioners. Responses are time sensitive and in the failure to respond can lead to a deemed approved assessment.

Where the insurer wishes the request may be subjected to a paper review wherein the insurer refers the request to one its own practitioners who reviews the paper file only and without ever seeing the applicant, to decide if the referral was reasonably necessary. Since the paper review doctor never sees the patient it is hardly surprising that no persuasive report is ever received, and further, that very few of these requests result in an OCF 22 being approved by the insurers doctors. This type of referral results in a needless expense for insurers.

A sensible solution is to leave the OCF 22 in place but leave the question of denied assessment requests to the dispute resolution thus eliminating a needless expense layer for insurers.

Where the SABS currently provide for the Applicant's right to a rebuttal report there is a current limit of up to $750.00. The problem is that increasingly insurers will request examinations by multiple examiners at a time. This effectively limits the Applicants ability to rebut the reports because the $750.00 limit is applied regardless of the number of specialties used by the insurer. In other words the SABS currently allows only $750.00 to rebut as many as 5-6 different reports obtained by an insurer at any one time. There is an obvious inequity, especially considering the disparity of resources available between Insurer and Applicant.

Insurers' counsel believes that the OCF 22 process should be done away with entirely. The issue of the cost of medical reports should be left to the dispute resolution process but should not be subject to the interest rate of 2% per month compounded if ordered paid. A disbursement is a disbursement.

Applicants' Counsel believe that the OCF 22 process by its nature requires insurer pre-approval and thus insures than an Insurer is aware of what is happening in terms of assessments to come. This in of itself represents a fair reason for maintaining a funding mechanism for Applicants to be able to present their case to an insurer with doctors of their choosing.

4. Further Insurer Medical Examinations

Insurers Counsel raise the issue of whether an Insurer, who has denied benefits, should nevertheless be entitled to further Insurer examination of the Applicant prior to arbitration. In the same manner, they argue, a right to a “defense medical” exists in the court system, and since a considerable period of time may pass from the termination of an insured’s benefit to arbitration that some updated examination is required.

In a number of cases, Applicants deliver updated expert reports during the arbitration process, and without their own updated assessment, insurers are unable to adequately defend arbitration proceedings. For insurers, this is also an issue of fundamental fairness and ultimately, it is in the interest of all parties that arbitration decisions be based on balanced and updated medical information, as opposed to updated information tendered by only one party. Insurers do not agree that the issue of "financial advantage" is pertinent to whether they should be entitled to a "defence medical".

The Applicants Counsel do not agree that the Insurers should be entitled to such further Insurer examination. The existing SABS provisions in s.42 are adequate and fair. Some Arbitrators have denied 11th hour requests by Insurers on the basis that such Insurer examinations are principally for the purposes of bolstering cases at arbitration rather than adjusting the claim. When additional information is provided to an insurer there has long been a duty to fairly consider the information and decide whether to maintain their denial. Insurers already have an enormous financial advantage over Applicants with respect to being able to fund the cost of Insurer medical examinations. The right of examination should exist for assistance in the adjusting of claims. More Insurer examinations will only make it more difficult for injured persons to fairly dispute their claim.

The above debate demonstrates well the shortcomings of the existing structure surrounding medical examinations generally. The Committee members have represented both Insurers and Applicants and can therefore provide valuable insight into the shortcomings of the present system and are therefore in a unique position to make recommendations for practical solutions. Such solutions will depend largely on any other structural changes being considered to the SABS overall.

5. Expert expenses under the dispute resolution practice code

Section 5 of Section F of the Expenses Regulation contained in the dispute resolution practice code provides for:

(1) Amounts paid for an expert witness to prepare a report to a maximum of $1,500.00

The amount provided for as above does not reflect the reality of the cost of having experts prepare a report. The result is that Applicants in particular are forced to take funds out of benefits ordered to pay for experts to provide opinions or prepare to testify or testify as a result of their accident.

In contrast when the Court system is accessed the amounts actually spent are recoverable, which can have the effect of forcing people to go to Court rather than arbitration because of the inequities in expert reimbursement.

It is suggested by Applicants that the amount payable for a report be left to the discretion of the Arbitrator hearing the matter as is done in Court matters.

6. SABS interface with WSIA

Insurers raise that SABS ss.59 presumed some level of harmony between the operation of the SABS and WSIA where there would be access to accident benefits on an interim basis under certain circumstances where there is ambiguity as to whether ss. 59(1) applied. In practice issues arise because neither Judges nor Arbitrators have jurisdiction to determine issues relating to WSIAT and the question of election between civil action and WSIA under ss. 28 and 30; standing of accident benefit carriers to come before the Board; collecting payments made by WSIA; the different standards of payments made between SABS and WSIA.

Ensuring that the two statutes work in a complementary way is a worthwhile goal so that applicants are not stranded between the two systems.

There is a strong belief that the interface between the two systems does not work in the current state of affairs and needs to be overhauled to insure that the interaction is fair to SABS insurers who pay benefits while awaiting confirmation that WSIA must take the claim. See the FSCO decision of Lin and Liu v. ING
for an excellent example of the practical problems that are being generated by the current state of affairs.

7. Disputes between Insurers

Insurers raise some practical issues which centre on, inter alia, the effect of insurers deflecting applications from both the standpoint of the Applicant who is without benefits and the subsequent recipient insurer who has no recourse against the initial non-compliant insurer; the lack of a speedy mechanism to resolve these disputes; the

impracticality of a 90 day notice period; widened ability to recover for adjusting costs, legal and interest fees in addition to the actual payouts from the non-compliant insurer.

Again, from an Applicant's view the key element in re- vamping the dispute between insurers provisions is insuring that a claimant is not prejudiced while two or more insurers argue about who should be in priority. Subject to this it is recognized that a fair method must be in place to allow for these disputes to be dealt with. The current system has been in place for a significant length of time such that the matters that do not work within that system are known and should be fixed.

8. Section 42 assessments

Insurers wish to see if the number of assessments that an insured is subjected to or an insurer is mandated to complete with respect to medical and rehabilitation benefits can be reduced.

Applicants, needless to say are in favor of reducing the number of assessments that are routinely asked for by insurers when a request for treatment is made.

As with the comments above regarding OCF 22, a fair system is desirable which keeps to a minimum the number of times a victim is subjected to insurer examination but at the same time allows for fair opportunities to assess the nature of the injuries suffered.

9. Interest provisions

Insurers would like to see the interest rate (which they consider to be punitive) made discretionary as opposed to mandatory. If it was felt that consumer protectionism was an issue they would be prepared to see the special award go to 60% of the benefit awarded.

Applicants believe that the interest rate provision is the only really effective tool to combat insurer behaviors of delaying or otherwise failing to pay benefits that are owed. The number of cases that get to arbitration is an infinitesimal fraction of SABS claims made to insurers, such that changing the interest provisions in the manner suggested by insurers would leave Consumers without any leverage against Insurer conduct.

10. Certainty within the System

Insurers would like to see the word "incurred"defined. The word incurred should mean that a service or item has actually been paid for, or that the commitment to pay has been made in exchange for the services or item.

Applicant's counsel believe that an insurer should not be permitted the opportunity to benefit from their failure to pay for a service that was reasonably required simply because an Applicant did not possess the means to underwrite or otherwise commit to the expense while the insurer withheld funding the benefit (see McMichael v. Belair). Applicants are of the view that the definition of "incurred" as developed in the case law is quite sufficient that a definition of a word is not required.

Generally though there is a concern that Insurers are uncertain as to what they may owe to a victim, and conversely, victims are at times uncertain as to what they might expect from the benefits system. The DRFG is again possessing of the requisite balance of experience from both perspectives to assist in striking that balance.

11. Collateral benefits interface

The interface between entitlement to weekly benefits, particularly income replacement benefits, and collateral benefits such as LTD payments, needs examining. This is particularly problematic by application of s.47 of the SABS which permits recovery of overpayments for the last 12 months only, unless there is misrepresentation or fraud. There are circumstances where claimants are receiving lump sum settlements for LTD payments that cover past, present and future that are not deductible from their weekly SABS benefits simply because they were received as a lump sum. Clearly, the intention of the SABS was to prevent double recovery of income benefit payment. The question arises of whether lump sums received as damages in settlement of Breach of contract cases against LTD carriers should interface or not with SABS insurer obligations. Consideration should also be given to a SABS provision that requires notice to a SABS insurer when there is a change in circumstances i.e when there has been a resumption of payments by an LTD carrier.

The Future

The Dispute Resolution Forum Group recognizes that there will be many other submissions made in other areas and by other groups. The above represents the "Top 10" items that it has been discussing most recently. Each of these items above would need to be examined in detail in the context of whatever other changes are being contemplated in the 5 year review process. We interpret the call for submission of issues to be just that; rising issues that need to be discussed in the context of the current SABS regime.

It is also abundantly clear now that every amendment of the SABS has a ripple effect that costs the system years of time trying to resolve.

The Bar Dispute Forum Group would be pleased to continue to act in any consultative or advisory way that the Government deems appropriate to take advantage of the

wealth of very practical experience that exists within our group regarding the application of proposed changes.

We thank you for your consideration of the above.

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