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14 July 2008.

Mr. Willie Handler, Senior Manager,
Automobile Insurance Policy Unit,
Financial Services Commission of Ontario,
5160 Yonge Street, 15th Floor, Box 85, Toronto, ON M2N 6L9
By facsimile (416) 590-7265, 4 pages

Re: Ontario Auto Insurance Five Year Review

Dear Sir,

I am grateful for the opportunity to present my comments for the Ontario Auto Insurance Five Year Review.

1. Affordability and Availability

- Cost of exams.
  It strikes me that insurers pay a significant amount of money for insurers' exams (IE). This clearly must be reflected in premiums. Therefore, consideration should be given to revising the IE system.

2. Consumer Protection

- Opening a claim.
  I recommend that upon receipt of notification of an MVA, the insurer promptly send the claimant information including: the contact information for the claims manager, the insurer's ombudsman, the privacy officers of the insurer and adjuster, and the contact information of the independent ombudservice, along with copies of the privacy policies for the insurer and the adjuster. If there is no ombudsman or independent ombudservice, the claimant should be informed of to whom inquiries should be made. If there is an independent ombudservice but it is only available to some claimants (e.g., policyholders but not other claimants) this should be clearly indicated.
- Delays by insurer.
  The SABS should specify more timeframes for actions and responses by the insurer. In the event that the insurer does not meet the timeframes, there should be some actions which are automatically required, such as: notification by the insurer sent to FSCO and the claimant; financial penalty payable by the insurer to FSCO and/or the claimant; making the time delay immediately eligible for mediation, and the claimant should be so informed.

  Examples of such timeframes could include:
  - Responses to inquiries to the ombudsman.
  - Responses to rebuttal reports. It would be helpful to have a definite timeframe for the insurer's reply. If there is no reply, perhaps the treatment proposed in the rebuttal should be deemed to be approved automatically.

- Responses to inquiries to adjusters.
- Non-payment of pre-approved expenditures. If these are not paid within 30-45 days, there should be automatic reporting and escalation of interest or penalty, which should be eligible for mediation. It should be noted that non-treatment to healthcare providers puts the claimant in an awkward situation.
- Sending a copy of the claim file to another insurer or another entity.
- Requests for sending a copy of the claim file, or extracts, to the claimant

- Consumer complaints process.
  - All insurers registered with the Superintendent, including reciprocals and other special entities, should be required to have an ombudsman. In the alternative, claimants should be informed to whom complaints should be directed, and this should also be made clear on the websites of FSCO and the insurer.
  - Entities which do not sell insurance to the general public should have a consumer complaints process for all claimants, not just for policyholders.
- Privacy
  - Insurers should be held clearly accountable for the protection and safe transmission of confidential claimant information

3. SABS

- Organisation of the SABS
  - I would suggest that the SABS be arranged in a more chronological order, corresponding to the typical order of events in the processing of an MVA. For example, in trying to understand the current rules for various kinds of examinations, it seems that one must flip back and forth.
- Consent forms.
  - I would suggest that consent forms be standardised. It seems that some consent forms, prepared by individual insurers or practitioners, are excessively broad.

    Examples of such forms would include:
    - Release of medical file to another insurer
    - Consent to insurer's exam
- Insurer's exams

  Concerns:
  - I am familiar with a number of problems at insurer's exams, regarding actions of the examiner, including: unscientific statements made by the practitioner, criticism of another practitioner's report to the claimant, disrespect for family member accompanying claimant, lack of following the terms of the consent form, incomplete reporting of data in the report, lack of following the health professional governing body's guidelines for third party exams, physical injury, and incorrect physical contact at the exam.
  - I am also familiar with problems with the exam facility, including: lack of substantive response to concerns addressed to management, washrooms which are not accessible
  - There have also been problems when the insurer let the exam facility complete at least part of the OCF 25 forms and let the facility send the OCF 25 to the claimant.

- There have also been problems where the insurer gave incorrect terms of reference to the examiner (often in a letter separate from the OCF 25), and problems where the insurer did not give the terms of reference to the claimant before the exam.
- There have been problems with incomplete OCF 25 forms, for example, not indicating the purpose of the exam, not fully identifying the practitioner, not fully identifying the exam facility, giving the impression that the practitioner is regulated when this might not be the case, and apparently back-dating of forms (especially when an amended form is prepared a few days before the exam).

Suggestions:

- I would recommend that certain terms of reference be incorporated automatically for all exams. For example, certain events occurring during the exam (e.g., injury) should be required to be included in the report, and the examiner should be required to call for medical and/or police assistance in the case of injury, etc. Also, cancellation fees, if any, should be the responsibility of the insurer not the claimant. Also data captured electronically should be included in the report in paper and electronic forms. Consequences for non-compliance with consent terms should be made clear. Minimum standards for the exam facilities (e.g., accessible washrooms) should be stipulated.
- As previously mentioned, consent forms should be standardised.
- Non-regulated health professionals should not be allowed to be examiners, unless they are under the direct supervision of a regulated professional.
- With the OCF-25 the following should be sent automatically to the claimant: CV of the examiners, any terms of reference given to the examiners, membership information re health professional colleges, a list of any findings by a college, a list of any restrictions on the professional's practice, privacy policy of the facility, contact information for the facility's privacy officer, contact information for management of the facility, and an indication if the examiner is an owner or manager of the facility.
- The insurer should be responsible for obtaining a current copy of the CV.
- Only insurers should complete OCF 25 forms and transmit them to the claimant.

- Fairness issues for insurer's exams
  - If there is a serious problem with the conduct of the exam, or with the contents of the report, what should be done? If the claimant complaints to the health profession college (and perhaps under other circumstances, e.g., there is a report of injury during the exam), I would suggest that the clock be stopped for the purposes of insurer's determination, rebuttal, mediation, etc.,
  - If insurers continue to select examiners, it would seem fairer to me that the exams be held at a neutral facility, where standards are maintained. In this way, neither the examiner nor the claimant are on "home turf", and if there is a problem, the claimant can turn to neutral management
  - Rather than the current approach of having insurers choose examiners, I would argue that it would be fairer if the examiner were chosen by a neutral entity.
    - Currently there can be a serious appearance of unfairness. Let us say claimant A seeks treatment B under circumstances C. Insurer D happens to know that examiner E generally does not recommend treatment B under circumstances C. So insurer D sends claimant A to examiner E. How fair does that look?

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- Currently the system of insurer's exam followed by rebuttal is lengthy and costly. I would suggest that the use of a neutral examiner chosen by a neutral entity would be speedier, fairer and more cost effective.

4. Dispute Resolution at FSCO

- Mediation
  - Where the insurer has caused delay, or otherwise acted inappropriately, the matter should be subject to mediation.

5. Other Issues

- Responsibilities of the adjuster
  - Adjusters should be required to respond to inquiries within a reasonable timeframe
  - Claimants should have access to the claims manager or similar official, in an effort to resolve things informally
  - Adjusters should be required to maintain contemporaneous notes of conversations with the claimant, health care providers, et al., and these should be in the claim file.
- Insurer responsibility
  - Where the insurer has caused a problem (e.g., misplaced documentation, incorrectly dated a form, etc.), it should have the responsibility to correct the matter. It should not inappropriately reverse the onus and put a further burden on the claimant.

Thank you for your efforts to conduct the Five Year Review. Thank you for taking the time to review my comments.

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