July 14, 2008

VIA EMAIL

Financial Services Commission of Ontario
North York City Centre
17th Floor
5160 Yonge Street
P.O. Box 85
Toronto, Ontario, M2N 6L9

Attention: Bob Christie, Chief Executive Officer and Superintendent of Financial Services

Dear Mr. Christie:

Please accept this as our written submissions identifying issues and concerns and to provide suggestions that will improve Ontario's automobile insurance system and comments on the Affordability and Availability, Consumer Protection, Statutory Accident Benefits Schedule, Dispute Resolution at FSCO of the Ontario Insurance Five Year Review.

Affordability and Availability

Improvements to the auto insurance system that maintain affordability and availability for consumers.

- **The current two-tiered medical assessment system.** Currently, insurers negotiate cost of examination fees with health practitioners conducting Section 42 Examinations.

  Proposal that there be a level playing field between Section 42 and Section 42.1 Examinations and that the cost of examinations under Section 42 is limited to those fees mandated under Section 42.1 – i.e. Paper Review - $450.00, Assessment by a physician other than a family physician - $900.00 and Assessment by any other regulated health practitioner - $775.00. This would reduce the costs of medical assessments and thereby reduce the premiums to consumers.

Consumer Protection

Further measures that may enhance consumer protection in purchasing auto insurance and accessing compensation and services following an accident.

- **The two-tiered medical assessment system.** The current two-tiered medical assessment system leads to inequality with the insurer having the ultimate power in an already unbalanced regime, which does little to protect the consumer. Insurers can negotiate with their chosen health practitioners what the practitioners fee will be yet the consumer's regulated health practitioner is limited to between $450.00 and $900.00 to conduct the assessment or examination.

  Proposal that all regulated health practitioners doing an assessment or examination either under Section 42 or Section 42.1 be paid the same cost of examination fee.

- **Regulate Section 42 Assessors.** Currently anyone having a complaint about a regulated health practitioner is directed to the respective college of the health practitioner. The colleges are ill equipped to deal with the complaints as only one college has a third party policy (and it is outdated) and the colleges do not and will not become fluent with the *Insurance Act, Statutory Accident Benefits Schedule, Personal Health Information Protection Act, 2004 and the Personal Information Protection and Electronic Documents Act* (*PIPEDA*). In rendering their decisions they refer the complainant to either FSCO's Dispute Resolution or to Office of the Information and Privacy Commissioner/Ontario (IPC) which creates a system where the insured has no alternatives and no protection. The Dispute Resolution is only for quantum and entitlement to benefits not about the conduct of the health practitioner and the IPC is only for Section 42.1 assessments or examinations as the health practitioner has a duty of care. Section 42 assessments or examinations fall under *PIPEDA* as the health practitioner has no duty of care.

  Proposal that FSCO set up mandated information sessions for all regulated health practitioners conducting Section 42 assessments or examinations and that a representative from their college also is mandated to attend.

  Proposal that FSCO through the Minister of Finance works with the Minister of Health and Long-Term Care to ensure that all regulated colleges have current up-to-date third party policies and that the policies do not go beyond that required to fulfill the explicitly specified, and legitimate purpose of a third party assessment or examination for the protection of consumers and the protection of the respective college members.

- **Access to clinical notes and records of Section 42 Assessors.** Currently an insured has to request access the Section 42 Assessors clinical notes and records

through either the Assessor themselves or through the Insurer Examination Centre. In a lot of cases the Insurer Examination Centre will deny the insured access to the clinical notes and records and the insured has no choice but to file a complaint with the Federal Privacy Commissioner of Canada. Currently, access requests through the Privacy Commissioner can take upwards of 2 – 4 years. In the meantime with the multitude of Insurer Examination Centres not all Centres will still be up and running by the time the access request is heard at the Privacy Commission. No on seems to have an answer as to where the clinical notes and records of an Insurer Examination Centre end up when the Centre closes.

Proposal that all Insurer Examination Centres (including the now defunct DAC) maintain in a secure storage centre all clinical notes and records of every Insurer Assessment or Examination conducted for a period of 10 years after the Centre has closed as well that they contact each and every insured that was assessed or examined (paper or in person) at the Centre stating where the clinical notes and records can be found after the Centre closes along with the option, that the Centre at no charge will send the insured a copy of the insured's clinical notes and records.

Standard Accident Benefits Schedule

Possible changes and improvements to the Statutory Accident Benefits Schedule in particular to reduce complexity and enhance compliance.

- **Rebuttal of Rebuttal Reports -** The current practice is that the insurer will have the insured assessed or examined according to Section 42. The insured is entitled to a Section 42.1 assessment or examination disputing the findings of the Section 42 assessment or examination (rebuttal report). Then the insurer commissions the original Section 42 assessor to complete a "rebuttal of a rebuttal" report based on Section 42.1 assessment or examination. This is in violation of *PIPEDA* as the consent that was provided originally was for one purpose and the "rebuttal of a rebuttal report" requires another consent according to

  Proposal – That the Statutory Accident Benefits Schedule be amended to reflect that the current practice of "rebuttal of a rebuttal report" ceases immediately and that any "rebuttal of a rebuttal report" be classified as an Unfair and Deceptive Acts or Practice as it is medical information that shall not be used or disclosed for purposes other than those for which it was collect, except with the consent of the individual.

- **Index of Documents or Documents List** are currently not being provided to the insured by the insurer when a Section 42 assessment or examination are to be conducted leaving the insured uncertain as to what documents are going to be provided to the Section 42 Assessor.

Proposal that all insurers provide a copy in date order of all medical documents that the insurer will be sending to the Section 42 Assessor and that it is an Unfair and Deceptive Acts or Practice not to provide the insured with a Index of Documents or Documents List.

- **Providing in date order Relevant Current and Up-to-date Information** is not the practice of an insurer when and if they do provide a documents list or index of documents to either the insured or the Section 42 Assessor. The insurer provides anything including non-medical information not relevant to the determination of a benefit which clouds and distorts the issue of entitlement to benefits.

  Proposal that all insurers when providing the index of documents or documents list that only relevant current up-to-date information is provided in date order as it pertains to the Section 42 and that non-essential information such a letters of complaint, outdated authorizations, etc are not provided to the Section 42 Assessor.

Dispute Resolution at FSCO

Possible changes that could improve the Dispute Resolution process at FSCO.

- **Pre-Hearing Discussions** are not currently being utilized to their full advantage nor are they being used according to the Dispute Resolution Practice Code. There are eight separate items detailed in Rule 33.1 of the Code, yet during the pre-hearing discussion only 2-3 of the items detailed are dealt with during the discussion.

  Proposal that a checklist be developed incorporating all of the eight items detailed in Rule 33.1 and that both the insurer and the insured adhere to the checklist during the pre-hearing discussions.

- **Exchange of Documents** is not being done according to the Dispute Resolution Practice Code found in the Practice Notes for Insurer and Insured. There are many delays from both parties in the exchange of documents.

  Proposal that both parties delivery to each other a document similar to the Affidavit of Documents found in the *Rules of Civil Procedure* and that the timeline be set out in the pre-hearing discussion as to when the document would be exchanged and when the documents would be exchanged. This would assist both parties as each party would know what information is still required from the other party.

Respectfully submitted,

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