The Advocates' Society

PROMOTING EXCELLENCE IN ADVOCACY

BY E-MAIL

September 20, 2013

Senior Manager
Automobile Insurance Policy Unit
Industrial and Financial Policy Branch
Ministry of Finance
95 Grosvener Street
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Dear Sir/Madam:

RE: Expert Review of Ontario Auto Insurance Dispute Resolution System (the "Expert Review")

INTRODUCTION

The Advocates' Society (the "Society") is pleased to offer the following written submissions setting out its perspectives on the Ontario Auto Insurance Dispute Resolution System (the "Dispute Resolution System").

The Society is a not-for-profit association of over 5,000 lawyers throughout Ontario and the rest of Canada. Our members practise as advocates in the resolution of disputes before courts, administrative tribunals, government bodies, arbitrators and other forums for dispute resolution. The mandate of the Society includes, amongst other things, making submissions to governments and other entities on matters that affect access to justice, the administration of justice and the practice of law by advocates.

Over 1,500 of our members practise in the personal injury field, both as plaintiffs' counsel and as defence counsel. The members of the Society's Task Force who drafted this submission (a list of the members of this Task Force appears at the end of this letter) represent both sides of the bar and this submission is the product of vigorous debate over the competing interests of claimants and insurers. As a result, we believe that our comments represent a unique and balanced perspective.

STRUCTURE AND EFFECTIVENESS OF PRESENT DISPUTE RESOLUTION SYSTEM

The mandate of the Expert Review is to examine the current Dispute Resolution System. As we understand it, that review is not limited to "tinkering" with the present system; rather, stakeholders are being asked to look at whether any other systems would be more appropriate.

To that end, the Society's Task Force debated at length whether there was some alternate system other than a combination of access to Court, arbitration and private arbitration that should be considered and recommended. There was unanimous agreement among the Task Force

members that while there were some systemic problems with the present Dispute Resolution System, the option to access three different levels of Court (Small Claims Court, Superior Court using the simplified rules, and Superior Court using the ordinary rules), in addition to the FSCO arbitration process and private arbitration process, ensured full access to justice on the part of consumers. The present system allows the insured to make the determination as to which forum he or she chooses to proceed in. This provides the insured with the option to proceed within the Small Claims Court jurisdiction, where it is anticipated that the costs would be lower, but where perhaps the judiciary would not be as familiar with the Statutory Accident Benefits Schedule (the "SABS"). Equally important is that the Financial Services Commission presently provides similar, more cost effective access, but with a specialized panel of arbitrators fully familiar with the SABS.

Again, despite vigorous debate on this issue, there was unanimity that the present system, with choices available to the insured as to where he or she would litigate, and with these choices left to the insured, was a fair system which enhances access to justice and considers cost effectiveness. Therefore the Society does not recommend any changes to the Dispute Resolution System with respect to its fundamental premise that the insured chooses where to litigate and the choices available to that insured.

PROPOSED CHANGES TO THE FSCO MEDIATION PROCESS

When the *Insurance Act* was amended in 1990 to provide for the Dispute Resolution System that we now have in place, the cornerstone of that system was mandatory mediation. While initially mandatory mediation did appear to provide a forum in which disputes were resolved, it is the view of the Society that over the years the system has lost its effectiveness and now is merely considered to be a stepping stone to litigation. Further, the volume of mediations and the requirement that each issue be the subject matter of a failed mediation before litigation can ensue, has resulted in significant backlogs. While we are told that the backlog has presently cleared, there is as yet nothing in place to guarantee that it will not occur again.

The mandatory mediation process and the significant backlog in unreached mediations have garnered a great deal of public attention. They also resulted, late last year, in a decision from the Court of Appeal clarifying the rules of engagement (see *Hurst v. Aviva Insurance Company*, 2012 ONCA 837).

The Society recommends that the process of mandatory FSCO mediations be abolished. What was designed and intended as a timely gateway to dispute resolution has become a barrier to dispute resolution.

The Society recommends that the mandatory regime of FSCO mediations be replaced with a **voluntary, opt-in system**, to be implemented retroactively. With such a system, any claimant could choose to access a mediator, but there would no longer be a requirement to obtain a report of a mediator before proceeding towards arbitration or litigation of a dispute. This recommendation is predicated on the expectation that mediation, in this form, would be delivered promptly. If mediation cannot be delivered in a timely way, even a voluntary, opt-in process is unhelpful.

In recommending the elimination of mandatory mediation, we were mindful of the following:

- A number of categories of disputed benefits are not well-suited to resolution at mediation, such as disputes over catastrophic impairment, disputes over home modification needs and expenses, or large disputes over entitlement to income replacement or non-earner

benefits. Rather than delineating disputes which require mediation from those which do not – which was an option the Society considered – we have concluded that the benefits of mediation are best achieved when no specific claim is required to proceed through mediation. Rather, mediation should be available for any claim, if sought. This is also more in keeping with the philosophy of mediation, which implies a willingness of both parties to participate.

- There are continuing benefits of mediation when it is voluntarily sought, particularly for the very small minority of claimants who are unrepresented, who most certainly do benefit from the guidance of a professional mediator;

- There is a real concern that mandatory mediation before FSCO has become a barrier to access to justice, which is the opposite of its initial goal;

- The reality is that many types of claims cannot be resolved in a non-binding mediation process, which renders the process simply busy work for insurer, insured, and FSCO in processing paperwork, simply to allow the parties to proceed to real dispute resolution;

- FSCO mediations have developed into a forum to discuss a lump sum resolution of the entire accident benefit claims file, something which can and should still occur by either party making contact with the other, outside of a formal mediation process;

- In some cases the fact of mandatory mediation has allowed the "buck to be passed" as it can have the effect of creating an incentive to deny a claim, leaving it for someone else, months later, to consider whether the claim should be paid. A process of voluntary mediation only would remove any incentive to pass a problem from the desk of the claims handler onto the desk of the insurer's ADR specialist.

With respect to the funding model, it is the Society's recommendation that the existing insurer-funded model of mediation continue in its current form.

By adopting this model, it is the Society's view that the Dispute Resolution Process can be made more streamlined, that cost savings can be achieved, that those who do need help navigating the system can still obtain knowledgeable help, and that access to justice can be enhanced.

PROPOSED CHANGES TO THE FSCO ARBITRATION PROCESS

The Society has reviewed a number of initiatives which we believe would enhance the principles outlined in the Expert Review mandate that the Dispute Resolution System be timely, cost effective and affordable, and prioritize the care and recovery of injured persons above other pecuniary interests. We also feel these recommendations will discourage frivolous claims and balance incentives for participation between the parties.

1. Cooling Off Period:

Should mandatory mediation be abolished, the Dispute Resolution Process should still require a procedural "buffer" or "cooling off" period between an insurer's denial of a benefit and an insured's right to dispute. Similar to the existing mediation process, the goal is to maximize opportunities for settlement while minimizing the risk that disgruntled insureds will flood the Courts or FSCO with Claims and Arbitrations. At the point where parties either a) agree not to mediate or b) fail to settle their dispute at a voluntary mediation, a brief "cooling off" period of perhaps 7-10 days should be imposed, during which the insured's right to commence litigation or arbitration is suspended. During the "cooling off" period, insureds will have, and should be encouraged to take, the opportunity to explore resolution of their disputes, thereby avoiding the additional costs and delays inherent in pursuing further proceedings. The cooling off period would offer insurers the same opportunity to reconsider their positions and to seek resolution of disputes – no doubt aware that failure to do so will inevitably prompt insureds to commence litigation or arbitration proceedings.

2. Certificate of Best Efforts:

The Society recommends that before both insureds and insurers are permitted to file either their respective Application (Statement of Claim) or Response (Defence), each must first file a form certifying their respective best efforts to settle or resolve the dispute. The certification form should not disclose the particulars of any settlement proposal; rather, it should articulate the "efforts" and means by which the party has attempted to further the goal of dispute resolution. At minimum, it would be expected that both parties be required to certify their participation in some form of direct settlement discussion as a condition to completing the form. When the question of costs is decided at the *end* of the proceeding, arbitrators (or judges) should be required to specifically consider efforts made by each party at the *commencement* of the proceeding.

3. Regular and Fast Track Arbitrations:

Our current Dispute Resolution Code processes uncomplicated, single-issue disputes in the same manner (and generally within the same time) as complex, multi-issue disputes. As a result, not only time, but also monetary resources can wasted on simple matters in which both insureds and insurers ultimately desire nothing more than a quick, inexpensive and fair adjudication of their dispute. The Society therefore recommends that criteria be developed by which to triage each Application for Arbitration into either a "Regular Track" or "Fast Track".

The "Regular Track" procedure would remain the same as presently exists and would be available for more complex, multi-issue disputes. "Fast Track" procedures could be implemented to process uncomplicated disputes in a quicker and more summary fashion. Procedural changes to be considered might include:

a) Strict timelines for the scheduling of arbitration hearings;

b) Strict timelines imposed upon arbitrators for the release of fast track decisions;

c) Limits on the time each party is permitted to present evidence and argument (similar to the Superior Court simplified procedure rules);

d) Admission of evidence by way of affidavit (similar to the Superior Court simplified procedure rules); and

e) Limits on the use of experts, expanded opportunities and/or encouragement to file expert reports, etc.

4. Documentary Disclosure Prior To The Prehearing:

At present, while there is a provision within the Dispute Resolution Code (Section 32.1) that parties should exchange documents prior the prehearing, this is, in fact, not enforced. Section 32.1 provides that 10 days before the prehearing discussion each party must exchange all documents identified in the Application for Arbitration and the Response by the insurer or explain why that document has not been provided. They are also asked to file a list of outstanding document requests and to indentify any disputed items. Section 32.1 then provides that the arbitrator at the prehearing will decide any disputes relating to the identification and exchange of documents and make orders in that regard. Rule 32.1 is simply not enforced. This may very well be because it is premised on the parties exchanging documents identified in the Application for Arbitration or the Response by the insurer. If no documents are identified, then there may not be any need for an exchange of documents.

The Society recommends that the Dispute Resolution Code be amended to make it a clear mandatory requirement that the parties do the following:

1) Parties are to exchange an "Affidavit of Documents" 60 days prior to the prehearing. We refer to the term "Affidavit of Documents" as it is a clearly understood document for those familiar with the Ontario *Rules of Civil Procedure*. This document would not have to be an actual affidavit. However, it should play the same role that the Affidavit of Documents does: clearly indentifying the documents that each side is prepared to produce and those they are not prepared to produce with a brief outline of the reasons why.

2) Then, at least 10 days before the prehearing discussion, each party must have provided to the other party the documents requested from each party's "Affidavit of Documents".

This would ensure that by the time the parties reach the prehearing they would have had an opportunity to review and consider each other's documents. This would be particularly important in the "fast track" arbitration. It would then allow the prehearing arbitrator to provide a more useful mediation role, as the parties would be familiar with each other's position as set out through the documents. Further, it would facilitate early settlement and, if settlement is not possible, it would allow the prehearing arbitrator to focus on documents actually in dispute rather than spending time asking each party to list their documents during the prehearing. The latter situation is generally what is occurring in the present process.

5. Defence Medicals:

The Society's Task Force did not reach consensus on this issue. Some members of the Task Force felt there should be a limited right to an "insurer's medical/defence medical" prior to an arbitration. The concern is that particularly with the regular track arbitration cases, insurers do not have an opportunity to secure updated assessments of the insured and to confirm that the position taken initially in the litigation is maintainable. Present case law at the Financial Services

Commission only allows the insurer the right to have a Section 44 assessment under the SABS. Many insureds decline to attend Section 44 assessments that are scheduled in the 12-16 months prior to an arbitration on the grounds that the sole purpose is to bolster the insurer's position in the litigation. FSCO case law has supported that analysis and, indeed, it is not an unreasonable one considering the insurer is seeking to have the insured assessed under Section 44. In order to allow an insurer an updated assessment, some members of the Society's Task Force suggest consideration of a limited defence medical to be set up under the provisions of the Dispute Resolution Code. This right should be only pursuant to an arbitrator's order. Some of the factors that the arbitrator would take into consideration would be the following:

1) The types of issues in dispute (is this a catastrophic claim, is it an income replacement benefit claim post 104 weeks);

2) When was this issue last assessed by the insurer;

3) Have new medical legal reports been served by the insured suggesting a change in circumstances;

4) Would it be unfair for the insurer to be obliged to proceed to arbitration without an updated assessment;

5) Is there consent on the part of the insured.

6. Arbitration Decision Guidelines

The Society recommends that strict guidelines be imposed requiring arbitration decisions to be issued within 90 days of the final hearing date. The legal maxim "Justice delayed is justice denied" is particularly relevant to FSCO arbitrations and applicants who are in need. We are hearing anecdotally of decisions being delayed more than a year, which is intolerable when one considers that the majority of arbitrations relate to claims for Income Replacement Benefits and/or Medical and Rehabilitation benefits. Accident Victims need compensation sooner rather than later.

The Arbitration process was introduced back in 1990 as a speedy alternative to litigation, yet lengthy delays at any stage work against this laudable goal. Accident victims and insurers both want certainty and finality to the claims process but significant delays on the part of arbitrators result in a serious loss of confidence in the system. Surprisingly, the SABS impose strict timelines on applicants and insurers at almost every turn but the release of arbitrators' decisions is left almost entirely to the discretion of the arbitrator. For the system to operate effectively, arbitrators must be held to strict guidelines which will allow both sides to anticipate the release of decisions. Currently, when a matter is delayed, counsel to both parties are reluctant to contact the arbitrator for fear of "tipping the scales" in favour of the opposite party. The old adage that "the squeaky wheel gets the grease" does not apply to arbitration because, for the most part, both sides are too timid to contact the hearing officer unless the delay is extreme. With a 90-day time limit in place, counsel may feel more comfortable with contacting the arbitrator after the 91st day and this would ensure a speedier resolution to all claims.

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7. Arbitration Costs/Award of Expenses

The award of expenses is governed by Section 75 of the Dispute Resolution Code. It provides that the adjudicator will consider only the criteria set out in the expense regulation (Section F of the Code). Those criteria include:

1) Each party's degree of success in the outcome of the proceeding;

2) Written offers to settle;

3) Whether novel issues have been raised;

4) The conduct of a party or their representative that tends to prolong, obstruct or hinder the proceeding, including a failure to comply with undertakings and orders;

5) Whether any aspect of the proceeding was improper, vexatious or unnecessary; and

6) Whether the insured refused to attend a Section 44 assessment.

While the rules with respect to costs would ostensibly allow an arbitrator to award costs to either party, a review of the expense awards would support the notion that generally the arbitrators, irrespective of the outcome, award costs to the insured. Keeping that in mind, the Society feels that to ensure that frivolous claims are not pursued at FSCO, there should be a better system of costs to cover those claims. The Society recommends that consideration be given to the following:

- Revisiting the expense regulation and Section 75 to provide more direction to an arbitrator that costs should be awarded in favour of an insurer in appropriate circumstances to discourage the present attitude on the part of some insureds and their counsel that there is "nothing to lose" by proceeding with an arbitration.

- Considering amending the expense regulation to allow for higher costs to be awarded to an insurance company's representative. At present, the insurer's representative is only entitled to recover costs on the legal aid scale while the insured's representative is entitled to recover costs on a higher level. The Society recommends that changes be made to make an insured and/or their counsel less inclined to take frivolous, inappropriate cases forward.

- Considering barring clinics from commencing arbitration or litigation with respect to outstanding treatment or assessments. This right should only be the insured's and should not be allowed to be assigned to the provider.

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CONCLUSION

These are only the preliminary comments of the Society. We understand an interim report is to be delivered in October of 2013. The Society requests the opportunity to make oral submissions to Mr. Cunningham prior to the release of the interim report. The Society also requests the opportunity to specifically respond to the interim report and asks for a further opportunity to meet with Mr. Cunningham for that purpose.

Yours very truly,

per Philippa Samworth
Chair, Auto Insurance Dispute Resolution System Review Task Force

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