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Consumer protection is one of the hallmarks of our No-fault auto insurance system. These two words, while succinct, remain the tip of the proverbial iceberg. While it may be easy to identify who the consumer is, it is a complex task to ensure he or she is truly "protected".

It may be reasonable to try to identify what we are protecting the consumer from. As in medicine, we should adapt the legendary mantra, "First, do no harm". The competing factions would say, for example, that in the case of personal injury, "harm" may come from an incomplete (or absent) financial support system. Others may question the need for any such extensive financial support in the first place. And others might address the provision of care to the injured consumer. A brief review of specific examples of this may be illuminating:

- While funding for the treatment of common injuries may be adequate, treatment Guidelines (and/or the actual provision of treatment under those treatment guidelines) may not be adequate. This may be an area where we can identify gaps in the system. For example, if the claimant requires physiotherapy, is he or she receiving proper treatment? Is that treatment following accepted/available treatment guidelines are those guidelines themselves adequate? Is the funding from insurers for specific treatment sufficient to treat the injuries/impairments? Could they be overtreating these injuries?

- While government or industry itself may identify that the cost structure and benefit choice provided to a consumer in an auto insurance policy may be adequate, insurers must protect the consumer to ensure the appropriate level of insurance benefits are selected in that consumer's auto insurance package. Does the consumer understand the nature of the costs of serious injury? Does the insurer even have a dialogue with the consumer regarding the provision of benefits, and, in particular, catastrophic impairment benefits? While government has announced the plan to re-instate the funding ceiling for reasonable and necessary catastrophic benefits to a maximum of $2 million from the present $1 million, this will add an estimated $600 million to the overall costs of such coverage. Will this be fully mitigated by the "group insurance" nature of the general auto insurance product and the "upselling" of the catastrophic optional benefits package to consumers? And if not, how will the catastrophically injured consumer be otherwise protected? It has become clearly obvious that only a small fraction of consumers actually take out optional benefits when renewing their policies. Financial viability for this product will, among other efforts, also depend on how industry is educating consumers as to the real personal costs of catastrophic impairment should they be unfortunate enough to sustain such serious injury.

- And what about the cost of "free" heath care in Ontario? This is a sub-surface issue for most Canadians who rarely think of the costs associated with medical care. In the past, under a subrogation agreement, the auto insurance industry paid back to the Ontario government a fee commensurate with the estimated costs associated with the treatment (under OHIP) of caring for auto accident-injured claimants. I do not know if this is still happening. Should this be explored further?

- What about the support to consumers regarding disability benefits? Within the "protection" aspect, are consumers being appropriately funded when they are unable to return to work? Are they being fully informed on their choice of these benefits? On the other hand, are retired seniors being advised that they can delete this section of their policies and save on their premiums? Is it a conflict of interest for insurers not to advise consumers of ways they can save on their premiums? Are consumers, in general, being made sufficiently aware of their options when renewing their policies?

- Are we to consider whether there is a political "balance" between financial consumer protection and the financial viability of the insurance industry? These are the two main competing variables but are not the only ones. Does the FRSA play any role or have any ownership or responsibility in any of the other issues? There may be an interaction with other Ministries, such as Social Services, Health, Finance (including Federal CCP funding and CRA taxation considerations) and perhaps others. Should we even consider those in this present exercise?

- While cost for treatment is an important issue, what about the costs of medical assessments? Because of the adversarial nature of dispute resolution, the diligence of such assessments has become even more necessary and nearly always are managed through multidisciplinary clinical evaluations. As the courts demand expert opinion, and as polarized legal teams pit their competing experts against each other ("My expert is better than your expert") these multidisciplinary evaluations have become expensive. While a $2000 ceiling on expert medical evaluations was first introduced in 2010 and was initially seen as problematic, it has now been fully accepted by both Insurer and Plaintiff lawyers who work in the Accident Benefits no-fault regime.

- Regarding regulatory restriction on Regulated Health Practitioners, the Ministry of Health and Long-Term Care has identified the *Regulated Health Professions Act, 1991* (RHPA) and Health Profession Acts (i.e., *Medicine Act, 1991*) as follows:

> In Ontario, regulated health professions are governed under the *Regulated Health Professions Act, 1991* (RHPA) and health profession Acts (i.e., *Medicine Act, 1991*). This legislative framework establishes health regulatory colleges, which regulate the professions in the public interest. Health regulatory colleges are responsible for ensuring that regulated health professionals provide health services in a safe, professional and ethical manner. This includes, among other things, setting standards of practice for the profession and investigating complaints about members of the profession and, where appropriate, disciplining them.
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> The *Health Professions Procedural Code*, which is Schedule 2 to the RHPA, sets out a comprehensive set of rules that all health regulatory colleges must follow when registering new members, investigating complaints, and disciplining members of the profession. These rules ensure that health professional regulation in Ontario is open, transparent, accessible and fair for those seeking to become regulated health professionals, for the regulated health professionals who are governed by the health regulatory colleges, and in particular, for patients and members of the public, whom the legislative framework is meant to protect.

It is my submission that any further regulatory restriction on Regulated Health Practitioners is unnecessary and, further, becomes not only cumbersome to apply but burdensome on already highly regulated professionals. Further regulatory restriction of Health Professionals does not offer any further needed consumer protection. To put this in another context, additional licensing requirements applied to Regulated Health Practitioners in order for them to be allowed to assess or treat consumers should be discouraged as being unnecessary and problematic.

- The issue of fraud is pervasive and the acknowledgement of such is important. However, there are different types of fraud and lumping them all together under the term "fraud" gives consumers an inaccurate view of the problem. This challenges their trust in the system. I would suggest the definition be subdivided into fraud by consumers (policy holders / accident victims), health care providers and insurers. While the former two categories are clearly recognized, the latter is more subtle and may only be apparent in reviewing court/hearing findings. Perhaps "fraud" as it pertains to insurers is too strong a term; however, misbehaviour by insurers, even on a small scale, given that the authority of insurers over consumers, is an overreaching issue. It shouldn't require the courts to identify these cases. And, importantly, consumers are becoming suspicious of insurer behaviour in a void of authoritative reporting on the subject. I recommend that an evidence-based identification of fraud in all three sectors be determined and this figure be used in the future in a contextual discussion of auto-insurance fraud.

These thoughts represent an incomplete list of issues to be considered in presenting a comprehensive model of no-fault auto insurance that offers, among other things, consumer protection to its customers. I welcome a fuller discussion.

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