Ontario Rehab Alliance

SUBMISSION TO THE THREE YEAR REVIEW OF AUTO INSURANCE BY THE FINANCIAL SERVICES COMMISSION OF ONTARIO

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INTRODUCTION

Our association is very pleased to have this opportunity to present our observations and recommendations about Ontario's Auto Insurance system. Our comments are focussed on Accident Benefits - that part of the system with which we are most familiar.

In preparation for this response we conducted a survey of health care professionals' experience with the current Accident Benefits scheme in order to inform our position and much of the data we refer to herein comes from this survey. Our survey reflects the experience of over 1500 clinicians and the 9469 treatment plans they submitted over the course of 2013, with much of the data drawn from HCAI (e.g. denial rates etc.). More information about the survey itself is provided in Appendix 2.

In addition to our efforts to collect quantitative data, we also gathered accounts of actual individuals and families whose experience in the auto insurance system illustrates a number of the points we wish to make. It is vital that decision makers appreciate the impact that a system gone awry has on those caught up in it. These stories will be found in the most relevant sections.

We offer the observations in this submission with the hope that this input will contribute to improving the capacity of the auto insurance system to better meet the needs of those injured as opposed to the systemic changes made over the past 18 years which tended to benefit insurers.

We make a number of recommendations in this submission. Some of our recommendations relate to specific and discrete aspects of system dysfunction at the operational level. Other recommendations call for significant policy changes and are, consequently, of greater importance.

Understanding the Structure of this Submission

We have structured this submission in a narrative and chronological sequence wherein we introduce ourselves (*About the Ontario Rehab Alliance*), outline what we see as the 'big picture' conditions of the auto insurance system today (*Environmental Scan*), and then reflect on the series of changes made to the system since the previous Five Year Review and their consequent impacts (*2010 Changes, Post-2010 Changes, Pending Changes*). Finally, we identify any other issues we consider important points for consideration (*Other System Issues*).

The Appendices include a Summary of Recommendations, a Survey Description, providing information about the survey and data that we refer to throughout the submission, and a copy of correspondence previously submitted regarding Insurer Examinations.

ABOUT THE ONTARIO REHAB ALLIANCE

Founded in 2009, the Ontario Rehab Alliance is a non-profit association representing 97 healthcare organizations with over 4000 healthcare professionals including physicians, neuropsychologists, physiotherapists, occupational therapists, speech language pathologists, chiropractors, psychologists, social workers, nurses, rehabilitation support workers, personal support workers and case managers. It is these professionals who are the primary providers of healthcare and rehabilitation services to the 65,000 Ontarians who are injured each year in automobile accidents.

Our member companies operate in the auto insurance sector as well as a variety of non-institutional sectors. As health professionals we have a strong duty of care to our clients; as business owners we have a responsibility to keep the businesses viable for ourselves, our staff, and the clients and families who depend on us. We share a common struggle to keep services reasonably priced while ensuring therapists are paid commensurate with public sector positions and offer effective services to our clients.

We are the only association focussed solely on the interests and issues of health providers in the auto sector. We assist our members to navigate the claims system with timely information bulletins and workshops on new requirements and issues, and tools such as templates for letters to insurers. We represent our members – and the clients and families they serve – through our advocacy efforts. In addition to meetings with politicians, public officials and the media we take every opportunity to offer constructive input into policy and regulatory development processes. Most recently, our association has participated in the Stakeholder Roundtable on Catastrophic Impairment organized by the Ministry of Finance, made presentations and submissions to the Dispute Resolution System Review panel, the Pre-Budget Hearings of the Standing Committee on Finance and Economic Affairs, and the Minister of Finance's Pre-Budget Consultation. Further, we attended FSCO's January presentation on the MIG Protocol Development Project. Lastly, we are very proud of our work relating to fraud prevention. Our association made early recommendations regarding licensing of healthcare providers and is currently a participant in FSCO's Healthcare Licensing Forum.

ENVIRONMENTAL SCAN

Continuous Change

The auto insurance sector has been undergoing near continuous change since 1996. As evidenced by this submission, the rate and profundity of change has escalated in the past five years. This creates destabilization and uncertainty for all stakeholders: consumers, accident victims, service providers, insurers, courts and regulators. Most disturbingly, the past year has seen a trend toward sudden announcements and regulatory changes made without warning or consultation, the most recent example being Bill 171 and the regulatory changes made effective February 1, 2014.

Our association is not alone in its perception of the negative impact of this culture of continual change, as evidenced by the following excerpt from Justice Cunningham's Final Report on the Dispute Resolution System.

> *I would agree with those who pointed out that the principle of predictability is undermined by the cyclical pattern of reforms to the system aimed at controlling or stabilizing costs. Each set of reforms introduces new benefit qualifications, thresholds, caps and tests that add uncertainty. I have been told that many previous reforms have been ineffective in stabilizing costs and have contributed to the complexity of the system.*
>
> *In addition, the SABS has become a complex and difficult document to interpret; many stakeholders noted that it is very difficult to work with it. Insurance companies need to make a considerable investment in training and developing adjusters, as does FSCO in respect to its mediators and arbitrators. Claimants need to find representatives well versed in the regulations. The learning curve associated with the SABS adds cost to the system. Other no-fault schedules are far less complex and not so procedure-oriented. Everyone would benefit from a wholesale review of the SABS in an effort to simplify the regulation.*[1]

In fact, the Three Year Review now underway takes place on a landscape that is still in motion from changes announced following the last review. Before the dust has settled and the impact of those changes properly assessed, and even before a number of plans announced in 2010 have been put into place, we experience additional, unforeseen changes being made to the system. Sadly, auto insurance policy seems to have become a political and regulatory playground in which the rules change mid-game and the game never pauses long enough for a proper evaluation of the activity and its impact on Ontarians.

Because all services, whether insurance, healthcare or legal in nature incur significant costs in adjusting to regulatory changes, it is best to minimize the frequency and number of changes in the system. Taking pause from continuous changes will benefit all stakeholders as it will allow players to establish working systems and gain long term efficiencies. We expect that such a pause will primarily benefit insurers whose systems are the most costly to change. It is a basic business fact that regulatory predictability is paramount to stable and efficient business operation.

RECOMMENDATION

#1 - We urge government to stop the cycle of continuous change and to take time between the mandated Auto Insurance System reviews conducted by FSCO to consult on, assess and develop policy and regulatory changes that can be left in place long enough to bring some degree of stabilization to the sector. A moratorium on changes between reviews should be imposed.

Claims Costs & Profitability

In this ever-changing landscape, one theme has not varied in nearly 20 years: auto insurers claim that costs are rising, profits are dropping and that changes must be made to the auto insurance product to protect them from further losses at the expense of those injured. This is nonsense. Benefits do not need to be sacrificed to lower

[1] p.14 Ontario Automobile Insurance Dispute Resolution System – Final Report

premiums; data available from the General Insurance Statistical Agency (GISA) makes it abundantly clear that auto insurance, and in particular Accident Benefits, is now highly profitable.

The positive impact of the 2010 changes on insurer profitability is just starting to be reflected in the numbers.

In 2012 the loss ratio for Accident Benefits (AB) in Ontario was 44. This means that out of every $1 in premiums collected with respect to AB, only 44 cents was paid out, leaving 56 cents on the dollar toward the insurers' bottom line. It is crucial to note that the AB 2012 Loss Ratio in Ontario was the lowest one in Canada, and the total loss ratio for Ontario 2012 was the second lowest in the country.

In real dollar terms, the data shows that Ontario insurers' AB costs have dropped from a high of $3,775,193,778 in 2009 to a dramatic $1,676,520,138 in 2012 – a decline of 68%!

Based on the above numbers, if the insurers cut their premiums by 15% the AB Loss ratio would settle at a very profitable 52% (from 44 in 2012).

To date we continue to see policy decisions made on the basis of insurer financial results dating back to 2008 to 2010. Since we no longer make reference to spectacularly strong insurer performance between 2004 and 2006, we should also stop making reference to poor performance between 2008 and 2010. We are now four years post such time, working under an unrecognizable Regulation. Policy decisions should be made on recent data reflecting the current regulatory landscape.

Lastly, previous regulatory amendments were based on the performance of the entire insurance industry. However, within the industry there are varying degrees of performance. That is, some insurers' outperformance of the sector is based on outstanding and innovative management. Previous regulatory changes had the tendency of throwing a lifeline to insurers who underperformed due to inadequate management rather than market conditions. Such behaviour rewards weak performers and punishes strong performance by levelling the playing field. It takes away any incentive to achieve internal efficiencies. We recommend that any future policy changes take such an analysis into account.

RECOMMENDATION

#2 - Accident benefits must be protected from further erosion.

System Imbalance & Lack of Consumer Awareness

The unsubstantiated claims of insurers have had a tremendous impact. Every regulatory and guideline change made since 1996 has benefited insurers' bottom line and hurt consumers, victims and service providers. The past year's efforts by government to restore some balance to the system by asking for a reduction in the cost of premiums has set off the now-predicable fire storm of protest from insurers crying poor. As expected from a multibillion dollar industry, their resources are disproportionate to those of any other stakeholder group. They have a loud, well-funded and well-connected voice and their efforts almost always bear fruit.

When it comes to buying auto insurance consumers don't know what they are buying and they are not getting what they think they paid for. Tragically, most don't find this out until they are injured. Most drivers assume that their medical and rehabilitation needs will be covered by the basic package most of us have, and the shortfall will be easily picked up by our publicly funded healthcare system. But they're wrong. The publicly funded system is severely underfunded and the current cap of up to $50,000 in med/rehab coverage for serious, non-catastrophic injuries which is, practically speaking, often 'converted' to the much lower spending cap of the Minor Injury Guideline, with a maximum of $3,500, is insufficient. This amount must cover not only physical injuries but also treatment for debilitating mental health conditions that can result from an accident. And, in many cases of minor injuries, claimants' treatment dollars often never exceed the initial $2,200, when provider applications demonstrating the need for the additional $1,300 are often denied. Our survey respondents reported that 26% of MIG clients who clearly required more care were unable to access more than $2,200 of MIG treatment dollars.

When the last round of changes to the SABS was made in 2010, there was much talk of improved consumer choice, with insured drivers having the option to 'buy up' so that they may – only if they need it and only if their insurance company agrees – access up to $100,000 or $1,000,000 in med/rehab benefits, access up to $72,000 in attendant care, and access to caregiving and housekeeping benefits. According to FSCO, only 1.4% of drivers have done this. Even when policy holders know enough to buy up, their benefit limits remain subject to the $3,500 Minor Injury Guideline, intended to capture upwards of 80% of accident victims. We believe that very few insured drivers have any idea about this.

These are numbers. But behind every number there are people – hurting, and trying to get their lives back. Many will never return to their pre-accident health and function levels. Many will find themselves fighting a losing battle with their own insurer to get the benefits they paid for. In the process many of them lose their employment, homes and most tragically, families.

As noted above, there are always cost reduction pressures to keep premiums low – but insured drivers and accident victims are not getting what the system was designed to provide. Any insurance system is meant to compensate and protect victims in the event of loss or injury. Instead, where we have arrived at today is a system preoccupied with insurer profitability, a system that seems determined not to fund accident victims' rehabilitation, and when it does so it is primarily through tort, supplemented by some small degree of Accident Benefits. This system gives so much protection to the insurers that the obvious result is a high number of denials or delays in treatment for those injured.

All agree that this province's Auto Insurance System is complex. Though the recent, high profile government policy to reduce premiums has received much attention, there has been little discussion of the desperate need for improved education of consumers, so that they can understand what they are purchasing when they buy auto insurance, and the implications of the decisions they make.

RECOMMENDATIONS

#3 - There must be clear, accessible and transparent channels for consumers to make complaints about insurer behaviour, and these complaints must be explored and resolved in a timely manner, with insurers held accountable by meaningful sanctions when found to be at fault. Data about these complaints should be compiled and publically reported so that the public has access to information about the quality of customer service across the insurance sector.

#4 - Medical rehab benefits and other critical benefits, such as attendant care, which are necessary to achieve rehabilitation, should not be optional. Making these mandatory parts of the AB package will restore some degree of insured protection. Insurers will continue to hold the purse strings and, as they do now, use the "reasonable and necessary" test to make determinations on access to benefits.

2010 CHANGES: Impact & Recommendations

High Denial Rates and Delays in Legitimately Required Treatment

The 2010 changes allow for denial of treatment plans without an Insurer Examination (IE), and time lines for completion of IEs are no longer required. Further, insurers are often not adhering to the requirement to provide "all medical and other reasons" for denial.

Our HCAI data shows that 28% of treatment plans submitted are not approved. Of those denied, 59% are never sent to an IE for a medical second opinion.

What does this tell us? It tells us that almost one-third of all treatment plans submitted by regulated health providers are denied in full or in part, and that the vast majority of these denials are made by adjusters without medical expertise and without access to a second medical opinion of an IE.

We believe that our survey respondents are those with a high degree of credibility and established reputations in the auto insurance sector. Most are members of our association and/or are closely affiliated with the professional associations (Ontario Society of Occupational Therapists, Ontario Association of Speech-Language Pathologists and Audiologists, and the Ontario Psychological Association) that participated in the survey.

What is the impact on innocent victims? The impact is that despite being 'insured', many claimants are being re-victimized by the system which now has a 'default' mode that treats most claimants – and providers - as if they are fraudulent. From our survey we can extrapolate that in 2013 approximately 7,800 of the 65,000 Ontarians injured annually in motor vehicle accidents were denied access to the insured services they had purchased to cover their rehabilitation on the basis of decisions made by adjusters with no medical background.

The HCAI data captured in the Ontario Health Claims Data Base Report released by IBC in December 2013 sheds some further insights on this situation. It shows the costs of insurer-driven exams and that they disproportionately contribute to total claims costs. It shows that in the calendar years of 2011 and 2012, Insurer Examinations

accounted for almost 30% of Medical and Rehabilitation Expenses[2]. Why are insurers spending so much more on insurer exams, rather than restorative treatment? Most of these exams come about for the primary purpose of denying claims for treatment.

Those whose treatment plans are sent to IEs, now often experience long delays in approval and treatment given that there are no longer any time frames established for completion of IEs. It is well documented in the research literature that injuries are more effectively and efficiently rehabilitated when they are treated early. However, the current system encourages extensive delays which contribute to greater difficulties achieving positive rehabilitation outcomes. We have heard many anecdotal reports and examples.

> *A 4 year old with a severe traumatic brain injury waited over six months for an IE for behavioural support. The therapy recommended was eventually deemed necessary by the IE, however his behaviour by then had deteriorated so much that his safety was at risk; e.g. he would run, scream and physically lash out for up to 1.5 hours, when asked to do routine things like getting into a vehicle to get to his special needs nursery school. He now needs even more intensive support at school and home than was originally recommended.*
>
> *A 27 year old woman with a severe knee injury waited over eight months for an IE for post-surgical wound care and bandages, a bath seat and toilet seat. In the meantime, her wound became infected and she had to have more surgery, resulting in the removal of a large amount of muscle and tissue. She also fell in the bathroom, re-injuring her knee. She now walks with a cane and a severe limp. She developed Post Traumatic Stress Disorder, and is afraid to stay home alone. The supports recommended was eventually deemed necessary by the IE, but she will never walk normally, without pain, and now requires additional supports such as occupational therapy and counseling.*

RECOMMENDATIONS

#5 - Insurers must be held accountable and strong sanctions applied for failing to provide the required medical and other rationale for treatment or assessment denials.

#6 - When denials for assessment or treatment do not include the required medical and other rationale, these requests should be sent to an IE.

#7 - The standard HCAI replies available to insurers should be amended to indicate the medical nature of the denial.

#8 - A decision-making framework should be developed to help adjusters determine what is reasonable and necessary. We would be pleased to assist developing this.

[2] p.51-52 Ontario Health Claims Database (HCDB), December 2013

#9 - Mandatory IE's should be reinstated unless certain conditions are met. For example, when a prior IE has determined the denial is reasonable, and no new information has been brought forward.

#10 - Timelines for completion of IEs should be restored to pre- 2010 standards.

Standards for IE Assessors

For many years, the sector has been rife with concerns about the lack of standards (credentials, expertise, and integrity) for IE Assessors and concerns about conflicts of interest have served to undermine the credibility of this important system component. Recommendations to develop such standards were part of the package of changes announced in 2010, and this was reiterated in the Final Report of the Anti-Fraud Task Force.

We have frequently commented on this issue. Most notably we submitted a comprehensive analysis if the IE components in the auto insurance system in our correspondence in June 2012 with the Ministry of Finance concerning the Mediation Backlog, attached as an appendix to this submission. While there are numerous checks and balances to ensure treating providers supply good services to the system, there are none for IE assessors. In fact, the incentive for IE assessors is to the contrary – the more requests an IE assessor denies, the "better" he/she is in the eyes of the insurer, and more apt to be on their preferred supplier list.

Over the past three years, three separate reports including the government's announcement of the 2010 changes, the recommendations of the Anti-Fraud Task Force, and the report of the Dispute Resolution System Review each recommended that steps be taken to improve the credibility of the IE system. To date, nothing has been done.

RECOMMENDATIONS

#11 - Develop standards for IE assessors. This was recommended as part of the last round of reforms, but has not been acted upon.

- As a starting point, prior DAC minimum assessor qualifications standards and competency form should be reviewed.
- IE assessors should be required to have a minimum number of years of experience in the area they are reviewing
- IE assessors should have a balanced practice (e.g., they conduct IEs and also teach at a recognized College or University; or they have a treating practice in addition to conducting IEs).

#12 - Insurers must be required to use qualified IE assessors and be held accountable when they do not.

#13 - IE assessors should be required to pledge adherence to the principles of objectivity, neutrality, and evidence-based opinion.

#14 - Assessments should be conducted on a 'Like for Like' basis, wherein the IE regulated health assessor should be of the same discipline as the proposing clinician.

#15 - Certification for IE assessors should be developed and implemented. The founders of the AMA Guides/CAT Certification Program in conjunction with the Ontario Rehab Alliance's Standards and Guidelines Committee have initiated an interdisciplinary IE certification course to commence in Winter 2015. Program development is led by the Alliance, a founder of the Chiropractic Independent Examiner certification course, and two members of the Coalition Representing Health Professionals in Automobile Insurance Reform in partnership with faculty of: University of Ontario Institute of Technology, Canadian Memorial Chiropractic College, York-University (Psychology Department) and University of Toronto (Rehabilitation Sciences).

16 - Standards for assessment procedures and reporting requirements should be developed by each health professional association, and be made mandatory for use by all IE examinations.

Introduction of the Minor Injury Guideline (MIG)

The Minor Injury Guideline (MIG) was introduced with a funding cap of $3,500 with prescribed treatment blocks, restrictive time limits, and no eligibility for attendant care, homemaking or caregiving benefits.

The MIG may be sufficient for most of those whose injuries are truly minor. We have always supported a Minor Injury Guideline but we believe, and our data shows, that this MIG is currently being used by insurers to routinely relegate to this category too many people with more serious injuries.

While our survey respondents indicated that many of those they treated within the MIG were appropriately placed, they reported that a disturbingly high percentage - 22% - of those they treated within the MIG were inappropriately relegated to this category and denied access to the higher benefit levels their injuries required. This is a significant number by any standard:

- 40% of respondents noted that insurers inappropriately kept clients in the MIG despite documented pre-existing conditions
- 50% indicated that documented evidence that the injuries were too severe to be classified as MIG was ignored
- 50% reported that no reason was given (ie. insurers just arbitrarily use "no compelling evidence" as a reason)

In most cases patients are receiving the initial $2,200 of treatment at which time requests for the further remaining amounts under the MIG are submitted under an OCF 18. Of those who were treated in the MIG, 26% were unable to access more than $2,200 when needed.

It appears that in many cases of true minor injury, the structure and timing of the MIG's proscribed treatment blocks creates an unnecessary barrier to effective rehabilitation, particularly when the minor injury is suffered by those with physically demanding jobs, requiring more extensive rehabilitation such as work hardening programs, etc. Our respondents reported that of those clients appropriately treated within the MIG, as a result of the treatment block timeframes:

- 47% could not achieve their Activities of Daily Living goals
- 48% could not achieve their Return to Work goals

In attending FSCO's January presentation on the MIG Protocol Development Project, we noted that Dr. Cote provided an important and quite consistent literature reference relative to the above survey findings. Dr. Cote indicated that data from the literature is now consistently demonstrating that only 50% of those with whiplash and neck associated disorders have fully recovered at 6 months post injury, while upwards of 30% to 50% remain symptomatic at one year post injury. As such, the above survey results pertaining to the extent of functional impairment subsequent to treatment within the MIG are highly compatible with the literature. The current MIG is therefore not appropriately managing the return to work needs of those with physically demanding jobs and other prohibitive limitations In turn, claimants will require prolonged Pre and Post 104 Income Replacement Benefits and eventually, substantially increased tort awards when they are unable to return to their jobs. Consequently this failure of the MIG places upward pressure on both AB and tort costs, and eventually on premiums.

In addition, the current structure of the MIG works to exclude the insured from receiving the necessary psychological or multi-disciplinary treatment they may require after an accident by focusing treatment solely on the physical components of impairment (given that the amounts covered for treatment can only address one aspect of patient care other than very modest funding for "psychosocial issues").

RECOMMENDATIONS

#17 - That distinct vocational rehabilitation funding be made available for those with minor injury, when the injury precludes a return to the individual's pre-accident occupation; and particularly, when such will result in exposure to high Post 104 IRB and tort awards due to substantive income loss without such intervention.

#18 - That an analysis of the most common rationale for the prohibition of access to services beyond $2,200 be completed.

Requirement to Show Prior Documentation of Pre-Existing Conditions

The SABS appropriately created an exemption to the MIG in cases where an insured person "has a pre-existing medical condition that will prevent the insured person from achieving maximal medical recovery from a minor injury if the insured person is subject to the $3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline." Under Regulation 347/13, this exemption was further restricted to apply only to a pre-existing medical condition "that was documented by a health practitioner before the accident".

The restriction of the exemption to pre-existing medical conditions that were documented before the accident appears to be understandably motivated to preclude every potential MIG claim from being subject to an exemption simply because a pre-existing condition is asserted after the fact.

However, this change has had an unintended adverse impact on entire class of those injured with severe pre-existing medical conditions: immigrants and refugees without access to pre-accident medical records. These

people are unable to establish prior documentation in most cases, even when they have an objectively verifiable pre-existing condition that will preclude maximal medical recovery under the MIG.

RECOMMENDATION

19 - Amend the language of the MIG Regulation as follows: Despite subsection (1), the $3,500 limit in that subsection does not apply to an insured person if his or her health practitioner determines and provides compelling evidence that the insured person has a pre-existing medical condition that either is objectively verifiable using diagnostic imaging or was documented by a health practitioner before the accident, and that will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the $3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.

Overly Broad Definition of MIG

The MIG was established to cover the average treatment costs for simple, uncomplicated whiplash type injuries. As presently worded, it covers many injuries such as partial tendon and ligament tears and joint dislocations that should have never been included in the definition. Injuries such as shoulder dislocations, rotator-cuff tears, and tears to ligaments in the knees (meniscus, ACL, PCL, MCL) are more serious and often require significant treatment, including surgical correction, hospitalization, and significant acute treatment and subsequent rehabilitation. These injuries do not belong in the MIG and should not be classified as minor.

RECOMMENDATIONS

#20 - The scope of minor injuries currently restricted to treatment within the MIG must be refined and narrowed so as to better permit injured people with serious injuries such as partial tendon and ligament tears and joint dislocation to obtain proper treatment.

The MIG and Brain, Mental Health and Chronic Pain Disorders

Recent developments (FSCO arbitration and appeal re Scarlett v. Belair Insurance and Director's Delegate David Evans' appeal order [FSCO P13-00014]) have raised concerns about a significant shift in MIG interpretation. Prior to these developments there appeared to be a relatively high degree of agreement amongst mental health practitioners and across IE/treatment providers that the presence of significant psychological disorders stemming from the MVA would exempt patients from the MIG. Currently, it appears that chronic pain, depression and other significant psychoemotional sequelae may no longer be considered for MIG exclusion.

Director's Delegate Evans has not made a ruling, but rather has provided guidance and ordered new arbitration on the matter and we understand that the case is also going forward to Divisional Court to challenge the FSCO Appeal Order. We are concerned about an eventual interpretation which may follow the reasoning of the Appeal Order.

To date, there has been little recognition of acute psychotrauma stemming from an MVA. The literature demonstrates that there is no direct correlation between the physical and psychotraumatic aspects of an accident. Acute psychotrauma may be experienced to the same extent by an individual with substantive physical injuries, moderate physical injuries or minimal to no physical injuries. Psychotrauma relates to the extent to which, as an accident is occurring, the individual perceives a significant threat to life or limb, regardless of the actual physical outcome. It is typically associated with an acute physiological reaction (the "fight or flight response") as the triggering event is unfolding.

An example of a severe psychotrauma associated with minimal/no physical injury would be that of a high speed spin- out on a busy highway, which miraculously doesn't result in a crash or physical impact. In the context of an MVA it is the psychotrauma which is ultimately responsible for the evolution of Posttraumatic Stress Disorder (PTSD), related in-vehicular and pedestrian phobias and in rarer cases, panic disorders and conversion disorders. Therefore, when a psychotraumatic event occurs and takes on a significant pathological course, the clinical status is no longer one in which there is strictly a "predominantly minor injury".

Similarly, providers have noted some tendency by a limited number of insurers to relegate those with mild traumatic brain injury (mTBI) into the MIG. By definition, a mTBI is a *brain injury* separate and apart from any otherwise occurring minor soft tissue injury. As well established by the Ontario Neurotrauma Foundation, evaluation and treatment of mTBI has a unique clinical course and evidence based treatment protocols[3].

As such, psychotraumatic disorders and mTBI, even when co-existing with soft tissue injuries, should never be in a contest as to which is the "predominant injury". Rather, the psychotraumatic disorder and/or mTBI are completely separate and distinct from the minor injury. Both disorders warrant specific consideration as to whether they are sufficiently severe in their own right to require reasonable and necessary treatment, regardless of a presenting minor injury otherwise.

RECOMMENDATION

#21 - The MIG should unequivocally state that Psychotraumatic Disorders and mTBI are exempt.

In addition to Psychotraumatic disorders, psychoemotional diagnoses/disorders include those disorders which occur in the aftermath of a soft tissue injury and typically reflect an adverse emotional response to the distress and functional restrictions brought about by the physical injury. These diagnoses/disorders go beyond the notion of "psychosocial sequelae" in terms of symptom severity and the distinct adverse functional impacts which they bring about. "Psychosocial sequelae" are referenced within the MIG, and are eligible for up to $400 of MIG based funding.

"Psychosocial sequelae" are considered to reflect normal distress associated with the early aftermath of a soft tissue injury, and by definition do not reflect clinically severe pathology requiring substantive treatment intervention. By contrast, psychoemotional diagnoses/disorders are diagnosed entities reflecting clinically severe

[3] Ontario Neurotrauma Foundation's Guidelines for Concussion/Mild Traumatic Brain Injury & Persistent Symptoms (Adults), Second Edition (2013)

distress and/or functional limitations. As such, they require treatment in their own right. Such conditions typically evolve over time in response to persistent soft tissue symptoms that increasingly wear down the patient's coping resources and/or cause increasingly greater adverse impact in the patient's life. The most common diagnostic entities which emerge from such a process include: Adjustment Disorders, Major Depression, Generalized Anxiety Disorder, and Pain Disorder. Assuming the presence of only a soft tissue injury then, as suggested by the Scarlett appeal order, one is hard pressed to argue that these conditions are not clinically associated sequelae of a minor injury. However, in considering the interplay between the concepts of "clinical associated sequelae" and "predominantly minor injury", careful consideration is required. More specifically, when the associated psychological sequelae reach clinical significance, as supported by the literature, the soft tissue injury should no longer be considered a "predominantly minor injury". Consequently, we believe that:

(a) **If** a psychological disorder is considered to reflect an adverse clinical response to a soft tissue injury; **and**,

(b) Alone or in conjunction with the soft tissue injury, results in at least moderate functional impairment; **then**

(c) The psychological disorder is deemed to require "reasonable and necessary" treatment, regardless of a presenting minor injury and as a result such injury is no longer minor.

RECOMMENDATIONS

#22 - The MIG Guideline should unequivocally state that Psychological Disorders giving rise to at least moderate functional impairments are exempt.

#23 - A clearer distinction between psycho-social sequelae and psychological impairments/disorders is required.

24 - The coexistence of demonstrable psychological impairments/disorders along with minor physiological injuries must exempt claimants from the MIG.

Benefits for Serious, non-Catastrophic Injuries Were Cut from $100,000 plus Assessment Costs to $50,000 including Assessment Costs.

Our survey data shows that of those who get access to the full $50,000, only 50% are able to resume *half* of their pre-injury roles before funding runs out. This is down from 85% prior to the September 2010 changes. This shows a clear correlation between higher level of funding and rate of recovery/goal attainment.

For those inappropriately relegated to the MIG, the cut in benefit was 96% ($100,000 to $3,500). It can be assumed that these people have little to no chance of recovery.

It bears reiterating that the $50,000 treatment funding cap is actually not $50,000 at all. With assessment costs factored-in, treatment dollars often amount to no more than $35,000. If the injured person is a CAT candidate,

then more of the benefit gets eaten by assessment cost and much less is dedicated for treatment. While some may consider this to be a sort of a "check-and-balance" in the system, this is in fact not so because if a client just misses the CAT classification they are still at the top of the "need" scale.

Previously, benefits for serious injuries lasted up to two years but now run out in as little as six months, long before the client has achieved their rehab goals. Those not immediately deemed as having Catastrophic injuries now have to wait years to access additional funds, during which time their status usually deteriorates and it may be too late for efficient, effective rehab. Our members see this now with a large group of their serious non-CAT clients, and the themes are consistent, as shown in the following case examples:

A 17 year old very high achieving student, who was an accomplished cellist, a skilled athlete and worked part time in her parents business, sustained a severe traumatic brain injury with bleeding in the brain. As a result, she suffered from fatigue, headaches, dizziness, personality changes (flat affect, anger management issues) and cognitive problems (poor attention, memory etc.). With therapy and academic support, and by giving up all of her social and extracurricular activities, she managed to graduate from High School and was accepted into university. Funding ran out in the middle of her first year, and she was forced to take out a loan, paying 28% interest per year, to have continued supports. That loan just ran out. Without support she is not completing her assignments, and is expected to either fail or drop out this semester. It is expected that she will not settle her CAT and tort claims for at least one year.

Note: It is sadly, not uncommon for patients in comparable situations to find that they have no choice but to take out high interest loans to fund much needed therapy, eroding any final settlement they might obtain and compromising their access to ongoing support.

A 48 year old mechanic's vehicle was hit by a bus going 90 km per hour. He sustained a traumatic brain injury with a GCS of 6/15. (This should qualify him as having a catastrophic injury but the insurer is fighting this). He also suffered numerous orthopedic injuries, including a severe injury to his right shoulder and hand requiring several surgeries. Initially he had occupational therapy and physiotherapy with an initial focus on his physical injuries as he had almost no use of his arm and hand, vitally important given his work. However, over time his cognitive impairment became more obvious. He started several fires as he forgot items on the stove, he was unable to focus to read, or remember what he read, etc. He ran out of med/rehab funds in six months. He was still unable to do any chores around the house, ride his snowmobile (his major social activity pre-injury), resume his volunteer work on a Board of Directors or return to his paid employment. He will now have to wait years for a CAT assessment and possibly access further support.

Note: Clients such as this who live in rural areas run out of funds even faster than others due to travel costs.

A female Human Resources Manager involved in a highway crash sustained severe injuries. She suffered a brain injury which caused her severe problems with memory, attention and organizational skills. Additionally, she sustained a crushed pelvis, and facial and arm nerve injuries which manifested with severe pain and paralysis. She ran out of med/rehab funds and then had to wait 16 months for a CAT assessment.

Though she was eventually deemed CAT, during this wait time she experienced major problems with the narcotic medications she required for her severe pain – waking up on the lawn one day. She could not travel to her cottage or ride her motorcycle as she was unable to sit for more than 30 minutes. She became socially isolated as she could not attend to conversation, dramatically affecting her interactions with her children and grandchildren. She underwent 15 IE assessments during this waiting period which her psychologist now reports contributed to her psychological deterioration.

Note: the time frames and number of IE assessments, and the negative impact on the client and family in this case are not atypical.

A homemaker's car was struck by a transport truck. She sustained multiple fractures and internal injuries. Two months post injury MRI scans showed that she had also sustained a brain injury. Two years post injury she was still unable to resume her household activities, manage her finances and continued to experience significant communication problems. She was referred to a speech therapist who determined she needed treatment, but funding had run out.

Note: This situation is not uncommon. Traumatic brain injuries may not be identified right away. Usually the first priority is to address the physical needs, and then there are often no funds remaining for other critical supports, such as occupational therapy, speech and psychology.

Importantly, there was no evidence that serious non-CAT med/rehab benefits were too high pre-Sept 2010. The rationale for most of the 2010 changes was to address abuse and fraud, which most agree occurs mainly in the minor injury area. Moreover, the introduction of the MIG, tightening of other regulations and pending licensure requirements will no doubt combine to substantially reduce abuse and fraud.

By cutting the non-Catastrophic cap to $50,000 while at the same time establishing a Minor Injury category with a cap of $3,500, the government in fact reduced the weighted average med-rehab cap for all non-catastrophically inured persons to $12,800. This is not only grossly insufficient level of med-rehab funding, but in fact the lowest of all Canadian provinces. Ontario's SABS is now officially the poorest system in terms of Med-Rehab funding. In order to bring funding to levels on par with other provinces, an increase in non-CAT cap to $100,000 and an increase in the MIG to $6,250 will be required. On a weighted average basis such increase will bring funding for all injuries (other than 1% of CAT claimants) to $25,000. Coincidently, this $25,000 is the cap recommended by FSCO as the cost base for all claimants (other than CAT) during the 2009 5-year review (before the Minor Injury category was contemplated).

The conclusions here are:

- The dramatic drop to a $50, 000 cap for the serious, non-catastrophically injured group is leaving almost all of those with serious non-CAT injuries under-protected, even those who will eventually be deemed CAT.
- These cuts were unnecessary to achieve the financial goals of cost cutting as analyzed by FSCO.
- Restoring the $100,000 cap for serious, non-catastrophic injuries is critically necessary.

RECOMMENDATIONS

#25 - Reinstate the $100,000 med/rehab benefit level for those with serious non-Catastrophic injuries.
#26 - Remove assessment costs from the med/rehab funding cap.

The Attendant Care Benefit for Serious, non-Catastrophic Injuries was Reduced from $72,000 to $36,000.

Prior to the 2010 reform, the Attendant Care benefit available to those who were non-catastrophically injured stood at $72,000 or up to a maximum of $3,000 per month. This means that the benefit was sufficient to last two years until the injured person had the chance to be evaluated for Catastrophic impairment status. With only $36,000 now available to the non-catastrophically injured, attendant care funding now runs out within the first year. This leaves many in unhealthy, and more importantly, unsafe situations that result in financial, physical and emotional stress on families who have to leave work to provide care, and who have no caregiver relief. By slashing the benefit from $72,000 to $36,000 for the non-catastrophically injured group, and eliminating it for those who have sustained a Minor Injury, the overall benefit was slashed by 90% from $72,000 to $7,200 on a weighted average basis for those two groups (representing 99% of all victims).

In fact, FSCO's last 5-Year Review recommendations did not include reduction of this benefit at all. As noted in connection with the Med-Rehab benefit, the 2010 slashes went unnecessarily too far when considering the establishment of the Minor Injury category. If the Minor Injury group continues to not be eligible to receive the Attendant Care benefit, while re-establishing the benefit at $72,000 for those who sustained serious non-catastrophic injury the weighted average for 99% of the victims will merely increase from $7,200 to $14,400 (still representing an 80% decrease from the pre-2010 Regulation).

RECOMMENDATION

#27 - Return to pre-Sept 2010 attendant care benefit levels for the non-Catastrophically injured group.

Payment of Attendant Care Benefit became Subject to Establishment of Incurred Expense/Economic Loss.

Perhaps the biggest problem with the current structure of the Attendant Care Benefit under the Statutory Accident Benefit Schedule (effective February 1st, 2014) is that regardless of what the assessed amount of the benefit is, payment is contingent upon proof of Economic Loss or Incurred Expense. There are two main reasons why this is problematic. First, consider that the hourly rate for attendant care services prescribed in the guideline to the Statutory Accident Benefit Schedule is not rooted in reality. In fact it is approximately half of the market cost for attendant services. So, while an assessment of Attendant Care may indicate a 24 hour need, the actual monetary amount paid by the insurer will be sufficient to fund only half or less of the time needed. The rest of the time needs to be creatively bridged by family members and friends if such are available. Instances where family or friends are

unavailable result in institutionalization of the injured person resulting in very significant costs to our publicly funded healthcare system.

This brings us to the problem surrounding Economic Loss. Because of the mismatch between the prescribed and market rate for attendant care, many victims resort to asking family members or friends to provide help at a reduced rate. If a victim wants to reimburse her family members or friends providing attendant care services, then she will need to prove that they have suffered a monetary loss. For the most part this would mean lost wages although some other expenses may qualify (at the insurer's discretion). The practical problem is that family members or friends providing attendant care would agree to do so if their earnings are equivalent or less than the amount paid by the benefit (which is close to minimum wage). For everyone else the decision is a difficult one: family members and friends providing the services have to either decline; or, help while being paid less than their current salary. And for those family members who did not work prior to the accident – they have to provide attendant services for free because economic loss cannot be readily proven. This means that if a stay at home mother caring for her children, now needs to also care for her husband injured in a motor vehicle crash, she will not be able to get paid under the attendant care benefit – implying that her occupation as a homemaker is worthless despite that fact that this contradicts the UN view on the subject. Here is just one case example:

> *A 30 year old working mother with a stay at home husband and a 4 year old child sustained severe orthopedic and neurological injuries, and as a result cannot work or care for their daughter. She is deemed to need constant access to attendant care for all waking hours. Her husband is providing this care. However, because he was not working at the time of the accident, the family having had elected for him to stay home to care for their young child, he is not entitled to any compensation. The husband is forced to leave his wife alone for short periods (e.g. to take his daughter to school), and as a result, the client has had falls on the stairs and further injury. The family lack the financial means to move to an accessible apartment or for basic things such as her medications and taxi to the PT clinic. The husband and daughter are now also showing severe signs of stress and deemed to need counseling.*

What if the person gives up their educational pursuits to provide the care? What if the person gives up intentions to return to employment, or begin a career, to provide the care? If a person has to alter all their life circumstances, including sleep, take attention away from other family members, their volunteer activities, their recreation and travel and/or give up education and future employment, plus be either accessible or providing direct care and/or supervision 24 hours of every day, 7 days/week, there is a "money's worth" to that service, significant loss of opportunity to generate economic gain, and a clear and significant value to the claimant of the service they are providing.

Equally as important is the need by some injured persons to be taken care of by family members who understand and share their cultural practices. For example, personal, intimate care raises modesty issues which function as a barrier to receiving care from non-family members. In such circumstances care must only be provided by a family member to whom the latest revision forbids payment.

Even if, for example, a family member caregiver was employed and earned $35,000/year working 7 hours/day, their "clear and convincing economic loss" is restricted to $2,900/month. But that would only cover their previous occupation for 7 of the 24 hours in which they provide the care and would not take into consideration the nature and extent of the service they are providing.

It is the value of the service to the injured person which is relevant here, not the economic circumstances of the person providing the care.

We state that care providers should clearly be entitled to be compensated with the attendant care benefit for the value of the services they are providing. There is a long standing principle of law that insurers cannot conscript family members to the service of the insured to save the insurer money. The effect of this definition does just that.

To remove access to these benefits in the manner done by this definition of "economic loss" is to effectively remove the attendant care benefit from the coverage for all claimants who need and are entitled to claim attendant care benefits. They are caught in a vicious cycle: the benefits are inadequate to pay for care at market rates and their option to purchase their care from family members or friends at well below market rates, and well below the value to injured person of the care, has been removed.

This creates serious safety issues and huge access to care issues for the group the government has expressed intention to protect, and it has serious implications for the public system. It is true that a public option for some degree of limited attendant services (personal support) exists through CCAC, however, funding restrictions contribute to scarcity of the service to families in need. The load in most instances falls on the shoulders of informal caregivers such as family members and friends. The Canadian Institute for Health Information has published concerning statistics regarding the impact such caregiving duties have on families. Distress levels are high with repercussions impacting not only the functioning of the family unit, but also performance in the workplace. It is clear that socio-economic cost is staggering which reinforces the need to Attendant Care benefit to reduce such anxiety and caregiver burnout.

The key point to bear in mind here is that this is an insurance product that drivers pay for, and as a result expect to access in the event of a loss.

RECOMMENDATIONS

28 - Limitation of economic loss should be reversed to coincide with that provided by the Ontario Court of Appeal in the Henry vs. Gore Mutual Insurance Company (2013 ONCA 480) case.

29 - Increase the Form 1 section 1, 2 and 3 rates to more appropriately approximate market rates payable to personal support workers providing attendant care services.

Both serious non-CAT and CAT- Caregiving and housekeeping benefits were made optional.

Less than 1.4% choose optional benefits. As outlined earlier in this report, few consumers and brokers/agents understand the med/rehab options and repercussions of their choices. Those who perhaps need the benefits the most are least likely to be aware of the option or be able to pay for it (e.g. single mothers, the elderly).

The lack of a Caregiver Benefit has resulted in children and the elderly left in unsafe situations. Consider the following:

> *An injured single mom is discharged home with her leg in traction (in bed). Without this benefit, how is she to get caregiving for her three young children?*
>
> *An elderly man sustains a brain injury and has difficulty caring for himself, never mind someone else. Who is now going to care for his wife who suffers from Alzheimer's Disease?*

Without a Housekeeping Benefit our patients have no funding for things like clearing snow from entrance ways, preventing them from attending therapy and participating in basic necessities of life.

RECOMMENDATION

#30 - Caregiving and Housekeeping Benefits should not be optional.

Assessments costs were capped at $2000

The $2000 assessment cap is preventing our patients from getting appropriate and necessary assessments and thereby treatment. Those who live in remote rural areas, those already deemed as having a Catastrophic injury and pediatric cases are particularly negatively impacted. Further, the more serious the injuries, the greater the negative impact because more specialized and hence expensive assessments are required. As this cap is also applied to IEs it has led to the hiring of less expensive and therefore less skilled and experienced IE assessors. Opposition to this assessment cost cap is shared by all providers and some insurers alike.

RECOMMENDATION

#31 - Remove the arbitrary cap to assessment costs and replace it with an assessments fee schedule to be developed in consultation each discipline's professional association.

POST- 2010 CHANGES: Impact & Recommendations

Non-Payment on Approved Treatment Plans and Incurred Services.

85% of survey respondents have experienced non-payment for services delivered further to preapproved treatment plans. A third of companies responding reported more than $100,000 in denied invoices for services that were pre-approved and delivered in good faith. This is a staggering amount by any measure.

A significant uptick in payment delinquency has been noticed after the 2010 regulatory amendment which decreased the penalty interest rate for late payments from 2% to 1% thereby reducing the incentive for timely payment. What reasons are provided for this non-payment? Each of the following was cited by at least one third of our survey respondents:

- No reason provided by the insurer; invoice was simply denied
- Med-rehab funding limit was reached without prior notification to the service provider
- Individual services provided did not match line by line to the approved plan

Providers are feeling as though adjusters are looking for any reason to deny invoices for previously preapproved services.

This represents a significant hardship to providers. Insurers are abusing their power by not providing a reason for non-payment. Insurers are also not tracking funds as they are required to, so that they are approving plans when there is not enough left. Providers are handcuffed by being prohibited from invoicing more than once every 30 days, meaning 30 days of service can be provided in good faith before finding out that the insurer does not plan on paying for those services. Treatment plans are estimates, and though providers do their utmost to forecast clients' needs they cannot always accurately predict some aspects of the treatment. For example, if a client's fatigue levels fluctuate, a proposed treatment time may be slightly shorter than predicted, or the proportion of direct vs indirect time may slightly vary if a provider spends less or more time on a report or treatment than predicted.

Insurance adjusters regularly contact service providers and pressure them to waive interest on late payment or reduce the amount due on an invoice for which services have been previously pre-approved. Service providers who have already paid the costs associated with the services (mainly to staff) are desperate to receive any sort of payment and usually capitulate. Taking such cases to small claims court is impractical because of the associated costs. Insurers are aware of their disproportionate power and take regular advantage of the much weaker service provider group.

We have raised this issue of non-payment of approved and delivered services with FSCO, and though FSCO is sympathetic, insurers are still significantly delaying payment. As service providers are awaiting the release of the cost schedule associated with licensing, the issue of payment delinquency is becoming more acute. We ask FSCO and the government to level the playing field and put new measures in place to ensure prompt payment for invoices of pre-approved services.

RECOMMENDATIONS

#32 - When insurers approve a plan, it should be made clear that they are approving the total amount of the plan, and despite best efforts to keep all line items within the pre-approved parameters, they allow the provider discretion to adapt the plan as needed to meet the specific changing/unpredicted needs of the client. Our association is prepared to negotiate with FSCO a mutually acceptable degree of internal variance if doing so will expedite resolution of this matter.

#33 - Interest rate on late invoices should be increased from 1% to 2%.

#34 - Negotiation of interest on late invoices is to be forbidden by insurers.

#35 - Systemic delinquency by insurers must be subject to UDAP and AMP.

'Anti- fraud' Initiatives

Since 2010 there have been a number of regulatory changes introduced with the purported intent of reducing fraud. A number of these measures do nothing to reduce fraud but merely add complexity, frustration and significant cost to health providers and/or their patients. Our association has raised these issues repeatedly, to date without resolution.

30 Day Rule - Superintendent's Guideline 03/11 and 07/12

This rule stipulates that providers may only submit invoices every 30 calendar days.

We understand the need for insurers to limit the frequency with which invoices are submitted and have suggested a frequency of once per calendar month rather than once every 30 days. At first glance this may seem trivial but in fact leads to two troubling problems:

1. Ordinary business practice is to run invoices over a few day period each calendar month. As months vary in length, this means that each individual client will need to be tracked and the time of invoicing altered every month (e.g., if Client A was invoiced on Feb 10 and Client B was invoiced on Feb 12, the clinic would need to ensure that those clients are specifically invoiced on March 12 and March 14, even if Client B's file was reconciled and ready to be invoiced earlier than Client A's file). This is a very time-consuming and administratively cumbersome process to manage and no one at FSCO has been able to explain how it curbs fraud compared to simply requiring invoices to be submitted no more frequently than once per calendar month.

2. If anything serves to disrupt the usual invoicing cycle for clinics (e.g., HCAI is down for maintenance for 2 days or an invoicing clerk is off sick or takes a week of vacation), the company's invoicing system is pushed back by 2-7 days every month going forward. For example, if invoicing normally occurs from the 7th-14th of the month but the invoicing clerk or therapist takes that week off in March, that means that invoices can't be done until March 15-22 – which then means that they can't be done until April 15-22 and so forth. Cash flow is therefore backed up by one week every month going forward, yet all business expenses continue to accumulate per their normal schedule. In addition, because administrative staff may be on vacation or fall ill, and HCAI does go down for maintenance at various points throughout the year, there is a cumulative effect which constantly pushes the week of invoicing forward by a week every few months. This results in providers having to skip billing for a month in order to get back onto a regular cycle approximately twice per year. This presents a serious cash flow problem if a company can't send any invoices out for services provided the month before.

Such commercial restriction cannot be found in any other industry. In fact, insurers typically bill premiums on a per calendar month basis and even HCAI generates financial reports on a per calendar month basis.

We note that our suggestion of amending the language requiring invoicing once per month vs. every 30 days (as currently is the case) does not add any administrative costs to the insurers because both instances result in no more than 12 invoices per year. During casual conversations, insurers pointed out that they are indifferent between the two options. Despite this fact, FSCO continues to resist change for an unknown reason.

RECOMMENDATION

#36 - A small change in wording from "once every 30 days" to "once per calendar month" will resolve a major problem for providers without any adverse consequences or cost to any other stakeholder group, including insurers.

Client Signatures Mandatory on all Treatment Plans

All providers are now required to have all OCF 18s signed by the claimant prior to submission of the OCF 18 to the insurer via HCAI. This amendment was made in 2010 when the OCF 18 was merged with the OCF 22 into one form. The formerly used OCF 22 provided for an optional claimant signature.

In most instances, the requirement for a claimant signature on the OCF 18 does not pose an insurmountable challenge and is in fact a good weapon in fighting fraud. However, there are a significant number of cases where this process poses serious barriers in the most acute and serious situations, such as with hospital discharges with little notice, post original injury, or unforeseen readmissions. Most such situations are handled by Occupational Therapists who usually facilitate such discharges. The crux of the problem is that the logistics of obtaining a client signature on an OCF 18 prior to a client discharge (when many discharges occur with little notice) are practically impossible. This flawed process results in two outcomes: 1) The claimant is discharged home without proper safety equipment, assistive devices or attendant care thereby exponentially increasing the likelihood of re-injury and readmission; or 2) The treating Occupational Therapist provides these urgent services without the benefit of a properly submitted OCF 18, thereby taking a significant risk of not receiving compensation for her work or goods purchased for the client. Neither is the intent of the Regulation.

We note that while this issue does not seem to impact victims who sustain Minor Injuries, it does appear to be problematic in the majority of Non-Catastrophic and Catastrophic cases.

Review of section 38(2)(b) of the Regulation points to the fact that the SABS does in fact allow for intervention on an urgent basis without the prior approval of the insurer. This is consistent with the government's repeatedly stated priority of protecting the seriously injured victims. The specific paragraph states the following:

> "*An insurer is not liable to pay an expense in respect of a medical or rehabilitation benefit or an assessment or examination that was incurred before the insured person submits a treatment and assessment plan that satisfies the requirement of subsection (3) unless,*

(b) the expense is for an ambulance or other goods or services provided on an emergency basis not more than five business days after the accident to which the application relates;

It is clear to see that this section was drafted in order to allow providers to respond to acute cases in a timely basis (i.e. without prior insurer approval). While we applaud the original intent of the section, we note that its practical application is problematic. That is, victims classified as MIG do not generally require any urgent intervention while those with the Catastrophic and Non-Catastrophic injuries do, but the latter two groups of victims are usually hospitalized for longer than a week, by which time this valuable clause becomes useless. In conversations about this issue insurers suggest that service providers should seek verbal approval. However, practically speaking, reaching adjusters for a live conversation is generally a difficult task not to mention during an urgent hospital discharge.

RECOMMENDATION

#37 - Amend section 38(2)(b) to the following: (b) the expense is for an ambulance or other goods or services provided on an emergency basis not more than five business days after the accident or discharge from hospital to which the application relates;

We do not believe that the minor amendment we're recommending will be a source for potential abuse because we are only asking to include provision of services to those who have been hospitalized for more than 5 days (i.e. the expansion over the current provision). We submit that those who have been hospitalized for more than 5 days are clearly seriously injured, and therefore not defrauding or abusing the system.

Non-Payment to Providers if Clients Unable to Confirm all Services Provided

A further 'anti-fraud' measure permits insurers to deny payment for delivered services if the client is unable to confirm that all services were provided. Though the Anti-Fraud Task Force recommended that providers keep treatment logs that document client signatures for treatment, the context of this recommendation was clearly intended to ensure that services, primarily in-clinic treatments, were not being billed for when the clients did not attend at the clinic. The requirement for signature at time of treatment is reasonable. However, health care providers often provide necessary, billable services that the client may not be physically present for such as report writing, contacts with others involved in the client's care, gathering quotes for equipment costs, etc. Further, it is often difficult for clients to recall exactly what occurred on a given day sometime in the past. This is particularly true if the client has a brain injury or other impairment that affects their memory.

Businesses pay their therapists/health care providers for the work that they do - and that has been approved by the insurer. When the business is then not paid for the approved services that were delivered, they are left with out-of-pocket losses, generally following time-consuming discussions with the insurer.

RECOMMENDATION

#38 - This regulation should be replaced by the original recommendation of the Anti- Fraud Task Force. Clients should be required to sign attendance logs when participating in assessment or therapy sessions and insurers

should be allowed to request copies of these logs. Clients should not be expected to be able to confirm indirect services and payment of therapists' invoices should not be withheld.

Dispute Resolution System

We were pleased to be an active participant of the Dispute Resolution System Review redesign process, meeting twice with Justice Cunningham and his panel, and submitting a formal response to the Interim Report. For the purposes of this submission we restrict our comments to what we see as one of the primary issues giving rise to disputes: the credibility of Insurance Examiners and their role in early resolution of issues.

Further to the recommendations made earlier in this submission with respect to IEs, we support the related observation and accompanying recommendation found in the Final Report of the Ontario Automobile Insurance Dispute Resolution System Review, excerpted below.

> *Part of the culture shift that I see being needed within the DRS is that medical experts appearing before adjudicators should have a duty to the DRS and not to the party that has retained them. The problem is obvious. An expert retained by an insurer who supports claimants is unlikely to be retained again. For this culture shift to be successful, the government will need to be proactive. The government will need to reach out to health professional associations and the insurance industry in order to educate experts on their duty to provide fair, objective and non-partisan evidence. In addition, I would like to see arbitrators ignore evidence that is not considered fair, objective and non-partisan and, in such instances, the expert should not receive compensation for appearing as a witness.* [4]

RECOMMENDATION

#39 - We support the Dispute Resolution System Review's recommendation that experts should be required to certify their duty to the tribunal and to provide fair, objective and non-partisan evidence. Arbitrators should ignore evidence that is not fair, objective or non-partisan and, in such instances, the expert should not receive compensation for appearing as a witness**.** *Please see Appendix 3 for our full set of recommendations, previously submitted in June 2012.*

Transparency, Proportionality & Balance of Sanctions

HCAI Data

Throughout all this continuous cycle of reform in the sector there has been much reference to quantifiable aspects such as the number of claims, the type of claims and the cost of claims. Since February 2011, all providers who bill insurers directly (the vast majority) have been required to submit treatment plans and invoices through the HCAI system. Thus, this system became a source of potentially rich and informative data. Good data is vital for analysis and policy development. Our association has repeatedly requested representation on the IBC-led committee that oversees HCAI, to date without success. Along with other stakeholders we waited for the release of this data,

[4] Excerpted from p.23 of Ontario Automobile Insurance Dispute Resolution System Review – Final Report

anxious to learn if the trends our members observed were in fact borne out by the other providers who use HCAI. Therefore, when the first report was finally released in December 2013 we were dismayed to realize how little practically useful data was provided.

The lack of usefulness arises primarily from the rolling, dynamic nature of the data and the reports. In other words, until a claim is settled it continues to appear in the data so that we see only snapshots in time. Thus, the longer the life of a claim the more years it will take until the HCAI data can serve as reference point for costs. This would not be an issue if it were not for the fact that insurers and policy makers seem determined to make system changes based on assumptions of rising costs and escalating claims. We believe the HCAI data hints strongly that there has been a significant reduction in claims costs as a result of 2010 changes, but we are unable to say so with certainty given the limitations implicit in the data reporting methodology.

Further, we were disappointed in the usefulness of the specific reports released in December. We subsequently inquired of the IBC about the possibility to mine for more specific and useful information and were shocked at the costs quoted, minimally requiring several hours per report and based on a rate of $250 per hour for data administration. This cost is completely out of line, makes access to such reports unattainable for all stakeholders, and calls into question the degree to which this system is transparent and proportional. We note that the vast majority of the information requested is available to each individual user of HCAI which means that it is easily attainable. The high hourly rate and number of hours quoted by the IBC leads us to believe that they are in fact not interested in disclosing this information. As a result, we were forced to undertake our own survey, within the constraints of our resources and time limitations, with a consequently much smaller sample size than could have been provided by IBC.

Lastly, we understand that the HCAI data released by IBC lacks integrity with respect to the types of injuries and related interventions reported because there is a lack of standardization for inputting the codes related to these categories. What value then does this data collection serve? Service providers have no wish to waste their time inputting codes in this context. Our association would be pleased to assist with the development of coding standards.

RECOMMENDATIONS

#40 – That the HCAI Committee membership be expanded to include representatives of the Ontario Rehab Alliance.

#41 - A standard HCAI report should be developed that includes data that is meaningful to all stakeholders and helps shape policy, rather than data that merely serves the interests of the insurance industry.

#42 – That HCAI Coding Standards be developed and coding simplified to improve the usefulness of future reports.

#43 - HCDB Reports must be available to all stakeholders at a reasonable cost.

Administrative Monetary Penalties

We are deeply concerned about the imbalance of 'accountability' in the system today. Much has been made of the implementation of Administrative Monetary Penalties, which are in place to address insurer divergence from regulation. We do not believe that the size of the potential fines serves as a meaningful deterrent to insurers, nor do we believe that these have been levied in any meaningful way. Previous sections of this submission have illustrated the extent to which insurers exploit the power that they have been given without experiencing any negative repercussions. There is little to no publically available information as to how – if at all – these penalties have been applied to insurers. The administrative burden associated with filing a complaint with FSCO's Market Conduct branch is extreme for both providers and patients. We are disturbed by the lack of proportionality in a system that applies the same size of a fine to a multi-billion dollar insurance company and a small health care provider.

Providers are held to account on a day-to-day, treatment-by-treatment, invoice-by-invoice basis by the design of the current system. The implementation of licensing will add further accountability requirements to service providers while insurers continue to operate arbitrarily, without regard for the legitimate concerns of their customers, providers and their patients as evidenced by the thousands of cases disputed by their own clients every year.

RECOMMENDATION

#44 – That proportionate sanctions for insurers should be developed and levied, and that information about sanctions imposed be made publically available and accessible. The quantum of financial fines for systemic abuse needs to be sufficiently significant as to have a material impact on their financial results. Patients and providers need to be able to inform FSCO of exploitative practices carried out by insurers with greater ease.

PENDING CHANGES: Impact & Recommendations

Service Provider Licensing

We have long been advocates for fighting fraud in the system, and lauded the Final Report of the Anti-Fraud Task Force. The Alliance has been on record as supporting the concept of service provider licensing since it was first proposed by the Anti- Fraud Task Force. The Task Force acknowledged that no other jurisdiction in North America has a comparable licensing scheme. Nevertheless, as a fraud-reduction initiative, it was the most sensible of all 2010 and subsequent auto insurance changes as licensing would actually deter the involvement of fraudulent players (whereas most changes introduced since 2010 have only served to hurt legitimately injured people and the clinicians who help them get better).

Two of our Board members are participating in FSCO's *Service Provider Business Licensing Forum*. We continue to hope that the new anti-fraud measures employed will achieve savings and enhance system integrity without adding undue burdens on the vast majority of honest providers and claimants.

While the Alliance continues to support the concept of a provider licensing system, we have to question if the anti-fraud benefit of such a system will outweigh the enormous additional administrative costs that will be downloaded to providers and insurers. FSCO continues to reference pre-2010 claims cost data to support the licensing program. That data is now four years old and can no longer be considered to be remotely representative of current claims costs. If every dollar spent on sustaining the bureaucrats who will administer the licensing program does not result in more than one dollar of fraud reduction, then the government will have created enormous additional complexity in the system for absolutely no benefit.

RECOMMENDATION

#45 - FSCO and the Ministry of Finance must reverse the post-2010 changes that only hurt legitimate victims and their providers in order to retain the support of the service providers for the licensing regime. Our support of licensing is predicated on the understanding that it is but one of a number of changes to improve the system for **all** stakeholders.

MIG Treatment Protocol Development

On January 17 we attended the recent Minor Injury Treatment Protocol Research Update Event. We commend Dr. Coté and his team for their commitment to the highest caliber scientific rigor in relation to the extensive literature review that they have undertaken to date. We had the opportunity to informally converse with Dr. Cote at the end of the session and very much appreciated his agreement to follow up on the literature pertaining to the efficacy of biofeedback (especially EMG) for the varied types of whiplash related headaches. While maximally only a small fraction of patients may present with post-traumatic migraine (and such a concept remains controversial in some circles), at least epidemiological review of this entity post WAD/NAD, and treatment efficacy review if indicated, would be an important additional contribution.

Further, the literature pertaining to minor injury related sleep impairments is relevant in order to identify effective interventions that may facilitate soft tissue recovery, as well as to document the impact of sleep impairment on minor injury course/recovery.

Additional important areas of literature review would involve the commonly occurring injuries stemming from low back pain and partial tears (e.g. rotator cuff). Such literature also requires coverage in relation to recovery times and treatment efficacy. Concerns have been expressed by a number of orthopedic surgeons that partial rotator cuff tears, which are quite commonly operated on, are being treated in the MIG.

The literature should also be surveyed regarding the one of the most common occurrence of injuries in the MVA context: *multiple* soft-tissue injuries and the synergistic impacts of such injuries both from the prognostic and treatment perspectives.

In absence of the literature review adequately surveying the scientific evidence regarding the above entities and interaction effects, the credibility of the final product will most certainly be undermined.

RECOMMENDATION

#46 - That FSCO state its position with respect to having Dr. Coté's project expand the areas of literature review to include efficacy of biofeedback, post-traumatic migraine post WAD/NAD, minor injury related sleep impairments, commonly occurring injuries stemming from low back pain and partial tears, multiple soft-tissue injuries, and the synergistic impacts of such injuries both from the prognostic and treatment perspectives. *Please see analysis and recommendations earlier regarding the limited access to the full $3500 cap, the limitation of the treatment blocks and the injuries that should result in exemption from the MIG.*

Proposed Changes to the Definition of Catastrophic Impairment

We have actively contributed to this discussion over the past several years. Please refer to our previous submission, *The Final Report of the Catastrophic Impairment Expert Panel to the Superintendent (April 8, 2011)* for a comprehensive articulation of our position.

The May 2013 round table showed there was clear consensus by all stakeholders excluding insurers that there is no support for the CAT panel or the Superintendent's recommendations to change the CAT criteria. The key point is that there no indication that there is a need for change; i.e. that too many people, or the wrong people, are accessing CAT benefits. In fact, the consensus is that given the cut in serious non-CAT benefits, if any changes were made, it would be to make the CAT definition more inclusive (not make it harder to qualify, as per the Expert Panel's and Superintendent's recommended changes), and ensure adequate coverage for those awaiting CAT determination.

However, there was agreement that the lack of standards and certification for CAT assessors has led to assessments that are unfair and/or biased. As in all IE situations, the system is inherently biased towards the insurer needs.

RECOMMENDATIONS

#47 - Make no changes to the current definition of Catastrophic Impairment and confirm that position.

#48 - Develop and implement standards and certification for assessors of Catastrophic Impairment, mandating that the AMA Guides/Catastrophic Impairment Certification Program (available since 2007) be required of all Catastrophic Impairment evaluators for both IE and plaintiff reports. *Please refer to our earlier recommendation on page 11 of this submission for details of an extension to this program currently under development*.

Bill 171

Bill 171 (Fighting Fraud and Reducing Automobile Insurance Rates Act, 2014), if passed, will remove the right of claimants to pursue court action, forcing all accident benefits disputes to be determined solely by arbitrators who do not have the power to award punitive damages, as do the courts. Removing recourse to the courts will eliminate an important tool to keep insurer misbehaviour in check. As described previously in this submission, experience has demonstrated that the current system does not properly respond to insurer misbehaviour and bad faith. The system requires more – not fewer – mechanisms by which insurers can be held accountable. Further, the

withdrawal of the right to take disputes to courts, imbedded in this proposed legislation will neither reduce fraud nor minimize costs.

RECOMMENDATION

#49 – Claimants must retain the right to pursue accident benefit disputes through the courts.

OTHER SYSTEM ISSUES

Offloading to Taxpayers & Unpaid Caregivers

As we have demonstrated in this submission, the series of cuts and changes since 2010 have left many insured drivers without access to rehabilitation and services necessary for their recovery. What is the impact on our publically funded health and social services as a result? It's not a pretty picture. Generally unable to access publically funded rehab and personal support, these people find themselves in situations that are costly to us all:

> *A recently injured and hospitalized MVA patient is unable to be discharged from hospital and return home. He's ineligible for CCAC-funded personal support and recently introduced changes in MVA-funded attendant care preclude the 24 hour coverage that he requires. He stays in hospital as a 'bed blocker', contributing to the growing Alternate Level of Care (ALC) crisis in acute care.*
>
> *Unable to achieve a level of functional rehabilitation from her serious, non-Catastrophic injuries following her MVA due a shortfall in treatment dollars, a young woman is unable to return to her work as a server and must apply for ODSP.*
>
> *When therapy funding ran out for a young man with a serious brain injury, his psychological state gradually deteriorated to the point of severe psychosis, requiring an extensive in-patient psychiatric ward admission. This same man later ended up in jail.*
>
> *While awaiting the determination of whether or not his injuries are Catastrophic, a middle-aged farmer loses access to therapy and attendant care when the funding caps are reached 13-months post-accident. Unable to farm or pay the mounting bills, he sells the farm and declares bankruptcy and applies for ODSP.*

These are just a few of the many stories that show is that one way or another we all pay when insurers do not.

RECOMMENDATION

#50 – Rehabilitation costs are a zero-sum game when considering the big picture. Deep slashes passed by the government during the 2010 reform simply shifted costs from the insurers to all tax-payers. This trend must be reversed.

Appendix 1 Summary of Recommendations

1. We urge government to stop the cycle of continuous change and to take time between the mandated Auto Insurance System reviews conducted by FSCO to consult on, assess and develop policy and regulatory changes that can be left in place long enough to bring some degree of stabilization to the sector. A moratorium on changes between reviews should be imposed.

2. Accident benefits must be protected from further erosion.

3. There must be clear, accessible and transparent channels for consumers to make complaints about insurer behaviour, and these complaints must be explored and resolved in a timely manner, with insurers held accountable by meaningful sanctions when found to be at fault. Data about these complaints should be compiled and publically reported so that the public has access to information about the quality of customer service across the insurance sector.

4. Medical rehab benefits and other critical benefits, such as attendant care, which are necessary to achieve rehabilitation, should not be optional. Making these mandatory parts of the AB package will restore some degree of insured protection. Insurers will continue to hold the purse strings and, as they do now, use the "reasonable and necessary" test to make determinations on access to benefits.

5. Insurers must be held accountable and strong sanctions applied for failing to provide the required medical and other rationale for treatment or assessment denials.

6. When denials for assessment or treatment do not include the required medical and other rationale, these requests should be sent to an IE.

7. The standard HCAI replies available to insurers should be amended to indicate the medical nature of the denial.

8. A decision-making framework should be developed to help adjusters to determine what is reasonable and necessary. We would be pleased to assist developing this.

9. Mandatory IE's should be reinstated unless certain conditions are met. For example, when a prior IE has determined the denial is reasonable, and no new information has been brought forward.

10. Timelines for completion of IEs should be restored to pre- 2010 standards.

11. Develop standards for IE assessors. This was recommended as part of the last round of reforms, but has not been acted upon.
    - As a starting point, prior DAC minimum assessor qualifications standards and competency form should be reviewed.
    - IE assessors should be required to have a minimum number of years of experience in the area they are reviewing
    - IE assessors should have a balanced practice (e.g., they conduct IEs and also teach at a recognized College or University; or they have a treating practice in addition to conducting IEs).

12. Insurers must be required to use qualified IE assessors and be held accountable responsible when they do not.

13. IE assessors should be required to pledge adherence to the principles of objectivity, neutrality, and evidence-based opinion.

14. Assessments should be conducted on a 'Like for Like' basis, wherein the IE regulated health assessor should be of the same discipline as the proposing clinician.

15. Certification for IE assessors should be developed and implemented. The founders of the AMA Guides/CAT Certification Program in conjunction with the Ontario Rehab Alliance's Standards and Guidelines Committee have initiated an interdisciplinary IE certification course to commence in Winter 2015. Program development is led by the Alliance, a founder of the Chiropractic Independent Examiner certification course, and two members of the Coalition Representing Health Professionals in Automobile Insurance Reform in partnership with faculty of: University of Ontario Institute of Technology, Canadian Memorial Chiropractic College, York-University (Psychology Department) and University of Toronto (Rehabilitation Sciences).

16. Standards for assessment procedures and reporting requirements should be developed by each health professional association, and be made mandatory for use by all IE examinations.

17. That distinct vocational rehabilitation funding be made available for those with minor injury, when the injury precludes a return to the individual's pre-accident occupation; and particularly, when such will result in exposure to high Post 104 IRB and tort awards due to substantive income loss without such intervention.

18. That an analysis of the most common rationale for the prohibition of access to services beyond $2,200 be completed.

19. Amend the language of the MIG Regulation as follows: Despite subsection (1), the $3,500 limit in that subsection does not apply to an insured person if his or her health practitioner determines and provides compelling evidence that the insured person has a pre-existing medical condition that <u>either is objectively verifiable using diagnostic imaging or</u> was documented by a health practitioner before the accident, and that will prevent the insured person from achieving maximal recovery from the minor injury if the insured

person is subject to the $3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline

20. The scope of minor injuries currently restricted to treatment within the MIG must be refined and narrowed so as to better permit injured people with serious injuries such as partial tendon and ligament tears and joint dislocation to obtain proper treatment.

21. The MIG Guideline should unequivocally state that Psychotraumatic Disorders and mTBI are exempt.

22. The MIG Guideline should unequivocally state that Psychological Disorders giving rise to at least moderate functional impairments are exempt.

23. A clearer distinction between psycho-social sequelae and psychological impairments/disorders is required.

24. The coexistence of demonstrable psychological impairments/disorders along with minor physiological injuries must exempt claimants from the MIG.

25. Reinstate the $100,000 med/rehab benefit level for those with serious injuries.

26. Remove assessment costs from the med/rehab funding cap.

27. Return to pre-Sept 2010 attendant care benefit levels for the non-catastrophically injured group.

28. Limitation of economic loss should be reversed to coincide with that provided by the Ontario Court of Appeal in the Henry vs. Gore Mutual Insurance Company (2013 ONCA 480) case.

29. Increase the Form 1 section 1, 2 and 3 rates to more appropriately approximate market rates payable to personal support workers providing attendant care services.

30. Caregiving and Housekeeping Benefits should not be optional.

31. Remove the arbitrary cap to assessment costs and replace it with an assessments fee schedule to be developed in consultation each discipline's professional association.

32. When insurers approve a plan, it should be made clear that they are approving the total amount of the plan, and that they allow the provider discretion to adapt the plan as needed to meet the changing/unpredicted needs of the client. Our association is prepared to negotiate with FSCO a mutually acceptable degree of internal variance if doing so will expedite resolution of this matter.

33. Interest rate on late invoices should be increased from 1% to 2%.

34. Negotiation of interest on late invoices is to be forbidden by insurers.

35. Systemic delinquency by insurers must be subject to UDAP and AMP.

36. A small change in wording from "once every 30 days" to "once per calendar month" will resolve a major problem for providers without any adverse consequences or cost to any other stakeholder group, including insurers.

37. Amend section 38(2)(b) to the following: (b) the expense is for an ambulance or other goods or services provided on an emergency basis not more than five business days after the accident or discharge from hospital to which the application relates;

38. This regulation should be replaced by the original recommendation of the Anti- Fraud Task Force. Clients should be required to sign attendance logs when participating in assessment or therapy sessions and insurers should be allowed to request copies of these logs. Clients should not be expected to be able to confirm indirect services and payment of therapists' invoices should not be withheld.

39. We support the Dispute Resolution System Review's recommendation that experts should be required to certify their duty to the tribunal and to provide fair, objective and non-partisan evidence. Arbitrators should ignore evidence that is not fair, objective or non-partisan and, in such instances, the expert should not receive compensation for appearing as a witness.

40. That the HCAI Committee membership be expanded to include representatives of the Ontario Rehab Alliance.

41. A standard HCAI report should be developed that includes data that is meaningful to all stakeholders and helps shape policy, rather than data that merely serves the interests of the insurance industry.

42. That HCAI Coding Standards be developed and coding simplified to improve the usefulness of future reports.

43. HCDB Reports must be available to all stakeholders at a reasonable cost.

44. That proportionate sanctions for insurers be developed and levied, and that information about sanctions imposed be made publically available and accessible. The quantum of financial fines for systemic abuse needs to be sufficiently significant as to have a material impact on their financial results. Patients and providers need to be able to inform FSCO of exploitative practices carried out by insurers with greater ease.

45. FSCO and the Ministry of Finance must reverse the post-2010 changes that only hurt legitimate victims and their providers in order to retain the support of the service providers for the licensing regime. Our support of licensing is predicated on the understanding that it is but one of a number of changes to improve the system for all stakeholders.

46. That FSCO state its position with respect to having Dr. Coté's project expand the areas of literature review to include efficacy of biofeedback, post-traumatic migraine post WAD/NAD, minor injury related sleep impairments, commonly occurring injuries stemming from low back pain and partial tears, multiple soft-tissue injuries, and the synergistic impacts of such injuries both from the prognostic and treatment perspectives.

47. Make no changes to the current definition of Catastrophic Impairment and confirm that position.

48. Develop and implement standards and certification for assessors of Catastrophic Impairment, mandating that AMA Guides/Catastrophic Impairment Certification Program (available since 2007) be required of all Catastrophic Impairment evaluators for both IE and plaintiff reports

49. Claimants must retain the right to pursue accident benefit disputes through the courts.

50. Rehabilitation costs are a zero-sum game when considering the big picture. Deep slashes passed by the government during the 2010 reform simply shifted costs from the insurers to all tax-payers. This trend must be reversed.

Appendix 2 2014 Accident Benefits Survey of Providers

In order to inform and support our submission to FSCO's Three Year Review of Auto Insurance, the Ontario Rehab Alliance surveyed providers working in the MVA sector in March 2014. The majority of respondents were from our own membership. However, the survey was also distributed by the Ontario Society of Occupational Therapists (OSOT), and the Ontario Psychological Association, (OPA).

Responses were based on corporate experience. In other words, sole providers responded based on their own practice (1 clinician), whereas those responding on behalf of larger organizations reported the experience of multiple clinicians.

Survey responses relate to the period of January 1, 2012 to December 31, 2013.

The results reflected the experience of over 1500 clinicians and the 9469 treatment plans they submitted over the course of 2013, with much of the data drawn from HCAI (e.g. denial rates etc.).

We asked respondents for essentially three kinds of information:

1. Identifying and Demographic Information – their name, company name, number of clinicians, respondent's contact information.

2. HCAI Data – respondents were asked to access their organization's HCAI data and to share those reports in their responses. These reports included:
    - Of Total Plans Submitted – the number approved in full, partially approved or denied.
    - Dollar amount denied for 2013.

3. In-house Tracking Data/Experience
    - Of plans denied in 2013, percentage sent for IE
    - Of those sent for IE, percentage approved in full, partially approved or denied.
    - Reasons provided by insurers for denial and/or no reason provided.
    - Percentage of clients inappropriately kept in the MIG
    - Factors ignored by insurers when clients inappropriately kept in the MIG
    - Of those appropriately treated in the MIG, percentage unable to achieve Activities of Daily Living (ADL) and Return to Work goals
    - Percentage of clients appropriately treated in the MIG unable to access more than initial $2,200
    - Post-2010 changes, percentage of seriously injured, non- Catastrophic clients that ran out of treatment funding before being able to return to at 50% of pre-MVA roles or comparable
    - Pre-2101 changes, percentage of seriously injured, non- Catastrophic clients that ran out of treatment funding before being able to return to at 50% of pre-MVA roles or comparable

Appendix 3 June 2012 Correspondence re Mediation Backlog and Insurer Examinations

Alliance of Community Medical & Rehabilitation Providers

June 12, 2012

Andrew Kovarciuk
Ministry of Finance
Via Email

Dear Andrew,

Re: ADR Backlog and Polarization of Medical Opinions

Following our meeting with you last November, we arranged a meeting of representatives from the Alliance of Community Medical and Rehabilitation Providers (the Alliance), the Coalition Representing Health Professionals in Automobile Insurance Reform (the Coalition) and the Association of Independent Assessment Centres (AIAC). Together, we brainstormed explanations for the increasing backlog as well as possible solutions. We have then continued consultations with a variety of other stakeholders in this industry. This letter serves to summarize the Alliance's thoughts on these issues and we look forward to meeting with you to discuss further.

There are likely a myriad of reasons for the 30,000+ backlog in the ADR system, and hopefully there will soon be data on the nature of the cases comprising the backlog to allow more refined analysis. On a purely logistical level, with providers and legal reps anticipating the September 2010 changes, there would have naturally been a dramatic increase in service applications and CAT rebuttals in the months before September 2010. However, there are a number of systemic issues which we believe are significant contributors.

It is important to point out that the systemic September 2010 changes will have the unintended consequence of deferring costs. We find ourselves in a situation now where insurers are denying almost triple the number of assessment and treatment plans with less than half of these denials being sent for a second medical opinion (insurer examination). Although we understand that few of these disputes have actually begun to be processed through the system to date, it is predicted that this fact alone will continue to place a high demand on mediation/arbitration systems. If such a prediction is accurate, the current state presents a distorted view of overall system cost and outcome effectiveness because of the associated deferred costs and delayed rehabilitation. Such deferred costs include those of future ADR and anticipated increased tort awards due to poorer claimant vocational and functional outcomes associated with blockage to timely access to rehabilitation.

We will first review some general developments over the past couple of years which will contribute to the ADR backlog, and then we'll review issues that relate specifically to the polarization of opinions between treating providers and IE assessors.

- Insurers, usually without medical training, frequently choose to deny assessment and treatment requests without seeking out an IE
- With the absence of IE time lines, insurers are suppressing medical evidence by keeping IE reports hidden for lengthy periods of time and choosing to deny funding for progress reports prepared by treating providers to limit the providers' ability to document rehabilitation procedures and outcomes
- Insurers are not supplying the "medical and other reasons" for denying assessment and treatment requests

    - *This results in a lack of confidence in insurer adjudications, pushing lawyers to resort to mediation/arbitration*
    - *This also results in increased time for insurer examinations and mediations when each side must perform more comprehensive investigations into broader issues, rather than being able to focus on what the insurer's particular concern is*

- There does not appear to be a "triage" process for mediation/arbitration requests and therefore all cases are treated in the same manner

    - *The nature of the dispute can sometimes be quite minor and/or obvious and could be resolved with an alternative process rather than requiring the full resources of mediation/arbitration*

With respect to factors which appear to be contributing more specifically to the *polarization* of the system, we offer the following observations:

- Insurers have more power to dictate which assessor they want to use (versus a geographically or alternate choice based assignment as in the DAC days) with the result that IE companies are more likely to try to influence assessor opinion in order to please insurers
- As seen through our survey, insurers are increasingly choosing non-peer evaluators when they do insurer examinations (e.g., requesting a family physician to review a request for speech-language pathology services)
- The Unfair and Deceptive Acts and Practices regulation was significantly dismantled to remove an insurer's obligation to select appropriately qualified personnel
- Since the dissolution of the Designated Assessment Centre (DAC) system, there have been no standards applied for qualifications of IE assessors so we have seen an alarming increase in the number of IE assessors who possess substantively less skill and experience than the treating providers whose work they are being asked to review
- The $2,000 fee cap is shifting emphasis to seeking low cost assessors instead of highly skilled assessors

    - *This results in a mismatch in expertise levels, which contributes to a polarization of opinions (e.g., while a family doctor technically has a scope of practice that subsumes most disciplines,*

research has shown that they make correct decisions regarding cognitive-communication disorders in less than 4% of cases)

- *Most disciplines have a range in their scopes of practice, so it is not a violation of College standards for an individual to provide commentary on an area they may not have the best level of expertise in, which then results in a mismatch in expertise and therefore a polarization of opinions*
- *If the IE assessor has less skill and experience than the treating provider, there is a much higher likelihood of a dispute*
- *Many individuals now being hired to do IE assessments have limited knowledge of applying the SABS regulations, so even if their clinical knowledge is adequate, their ability to map that onto SABS funding requirements may not be*
- *As documented in a number of arbitration decisions the assessment cap is resulting in an increased number of cases where IE companies are writing reports based on verbal or point form observations made by the actual assessor.*
- *As illustrated at a previous meeting with you, some IE companies are openly instructing their providers to limit review of the medical file in order to provide services at a lower cost.*

- Checks and balances (such as requiring an IE and allowing treating providers to prepare rebuttals to an IE) have been removed

  - *With no option to rebut an IE report, the treating provider is prevented from highlighting areas of weakness in the IE report which might alter the insurer's decision, which then results in referral for mediation*

- With advances in road construction, vehicle safety and medical procedures, more injuries are in the milder range

  - *It is in the milder range, the "grey areas" where there is naturally more disagreement because impairments are not as obvious*

- With the 95% reduction in benefits for minor injuries and the 70% reduction in benefits for serious but non-catastrophic injuries, there is more incentive to look for additional funding for injuries sustained

  - *The evidence is mounting rapidly that the new limits do not provide sufficient funds for many injuries, so it is in the disabled person's best interest to try to get reclassified into the next higher funding category*

The DAC system was certainly not perfect, however there were a number of features that were effective. To provide a summary of the pros and cons of the DAC system:

<u>Cons</u>

- Some DACs had previously largely been IE facilities with more of an insurer leaning, thus not perceived as neutral

- Lack of fee constraints for many (not all services) & lack of competition likely inflated some assessment costs
- Earlier DAC protocols allowed a given DAC to only address one benefit; this was later appropriately rectified so that multiple entitlements could be addressed in given referral

Pros

- Inherently more neutral given decreased linkage between referring insurer and IE centre; no contractual relationships which tends to lead to centre/insurer bias
- Assessors rarely felt pressured to give an insurer a leaning opinion (other than with some more insurer oriented facilities, but even there to a lesser extent it seemed)
- Clinical protocols were more best-practice based rather than low cost driven (e.g., IE companies are encouraging assessors to not review all documentation in order to save time)
- Clinical protocols were more uniform as at least some had DAC Manuals
- Higher level of clinical qualifications established maintained in transparent manner (DAC Assessor Summary)
- Better communication/education of assessors through annual ADAC conferences and re FSCO communiques re best practices and relevant court/arbitration outcomes to update/inform assessor opinions
- Through DAC statistical reporting to FSCO, better opportunity for FSCO to monitor outcomes and potential bias (although this potential seems not to have been fully realized)
- No known conflict of interest concerns in relation to insurer ownership of DACs
- Stringent conflict of interest guidelines with respect to DAC assessor pre/post involvement on given file

Our solutions to these problems are as follows:

- Insurers must be required to supply their "medical and other reasons" for denying an assessment or treatment plan to the treating healthcare provider in all cases with lack thereof resulting in a UDAP.

- Guidelines need to be developed for insurers to know when an IE is necessary (e.g., an IE should be required anytime insurer challenges a request to move to a higher benefit category and at least when denying the first request for assessment or treatment on a file). We have representatives who will happily assist with the development of such guidelines.

- Standards for IE assessor qualifications and procedures need to be developed. This requirement was recommended as part of the last round of reforms, but has not been acted upon to date. As a starting point, prior DAC minimum assessor qualifications standards and competency form should be reviewed. The Ontario Association of Speech-Language Pathologists and Audiologists voluntarily created such guidelines and submitted them to FSCO for review in the fall of 2010 (copy enclosed). For example, IE assessors should be required to have a minimum number of years experience in the area they are reviewing, and they should have a balanced practice (e.g., they conduct IEs and also teach at a recognized College or University; or they have a treating practice in addition to conducting IEs; etc.).

- Insurers should be held responsible for using IE assessors who they know to be unqualified. There are many historical examples of unqualified or openly biased IE/IME assessors who the insurance industry has used on numerous files resulting in real hardship and permanent damage to victims.

- IE Assessors' qualification summaries should be easily available for anyone in the system to review (e.g., in the OSLA program, anyone can contact OSLA and obtain a copy of the qualification information submitted by the IE Assessor)

- Acknowledgement duty. In parallel with recently enacted requirements for medical-legal assessments, IE assessors should sign a similar Acknowledgement to Form 53 (copy enclosed) requiring the assessor to pledge to adherence to the principles of objectivity, neutrality, and evidence-based opinion. Such an acknowledgement would be affixed to each and every IE assessment report.

- Return to like for like (peer) assessments. In performing IE assessments pertaining to OCF 18 reviews, the IE regulated health assessor should be of the same discipline as the proposing clinician/OCF-18 plan supervisor (or clinically most aligned assessor if there is a better fit for the proposed plan). Our membership reports that like-to-like assessments are not conducted in 35% of all cases. This has the tendency of sparking disputes as victims representatives claim that an IE was performed outside of the scope of the assessor.

- Required certification/training/continuing education for IE assessors. This concept would for example serve to assure that IE assessors remain knowledgeable and current about rehabilitation focussed clinical best practices, pertinent MVA regulations and case law relevant to entitlement determinations

- Allow rebuttals in response to IE reports

- Re-establish timeframes for referral and completion of IEs

- Restore non-cat non-MIG funding to $100,000 plus assessments

- Business ethics standards need to be developed for both clinician and IE organizations. The Alliance shared a draft of such standards with the Anti Fraud Task Force in December 2011 (copy enclosed).

- HCAI and other systems could provide feedback to treating clinics and IE assessors regarding performance relative to average. However, such data would need to consider claimant demographic considerations as well as consideration of the origin of arising disputes (e.g., treatment plans arising from rogue clinics wherein those plans are rightly denied and are highly represented within an IE clinic/provider's referrals).

- Contractual relationships between insurers and IE companies should emphasize quality and timeliness of assessments and adherence to operating principles rather than cost.

- There should be transparency in the RFPs posted by insurers describing the desired contractual requirements for IE companies to adhere to, and the selection process IE companies will go through for the RFP

- The selection process for insurers to obtain an IE on any given file needs to be reviewed for methods to improve neutrality

- IE companies with a majority ownership by insurers or adjusting companies should not be permitted to operate within the system due to the perceived and/or actual conflict of interest

- The $2,000 assessment fee cap needs to be removed to return to an emphasis on quality instead of cost. A number of individual associations have submitted proposals for an improved assessment cap system on the treating provider side and similar proposals could be reviewed on the IE assessment side.

It is recognized that bias may be present both in IE assessors as well as in treating providers. However, there are checks and balances in the system to manage bias in treating providers (e.g., insurers can deny assessment and treatment requests and can request an IE opinion). The reason we emphasize the need for reducing IE assessor bias is because all the checks and balances to monitor their work were removed in September 2010. Treating providers have "carrots and sticks" to encourage good work, but IE assessors do not. On the IE side, the incentive is in fact to the contrary – i.e. the more requests an IE assessor denies the "better" he/she is in the eyes of the insurer.

We also understand the government's confusion when most ADR settlements are for cash rather than treatment, which calls into question the value of treatment. However, two things must be kept in mind:

- Some providers and lawyers agree to provide treatment while awaiting the outcome of the ADR process given that the process is so lengthy, so cash is needed to reimburse the provider(s) for these services.
- When a client goes without treatment for a year or more, the benefits of treatment are reduced and the client begins to feel in an entrenched hopeless state.
- When brain injury is the diagnosis, poor decision making is a common characteristic so clients who could benefit from ongoing therapy sometimes choose to spend money on more concrete items. To see the true outcome for these individuals, the government needs to look a couple years down the road post-settlement. The prevalence of institutionalization for psychiatric disturbances and criminal offences is high. The Ontario Brain Injury Association has some excellent data regarding this.

Finally, additional clarity is needed when comparing Ontario's accident benefits system and those found in other provinces. It is our belief that when apples are compared to apples, Ontario's system is the second poorest in the country. This belief is based on a weighted average calculation of benefits available to different injury severities and different levels of public funding available in other provinces (e.g., there is next to no rehabilitation funding in Ontario anymore). The Alliance is planning a study in this regard.

The above is meant not only as a solution to address the backlog in the ADR process but also to bring transparency and fairness to the system. We believe that the public is losing confidence in the system. This is

clearly contrary to the intent of the insurance product which is supposed to bring peace of mind to its consumer. We believe that the recommendations provided herein will address this issue.

We trust that this document is the first step in outlining out thoughts on the subject, but hope that the government will continue to work with us on drilling down on the topics covered herein to resolve the issues which are plaguing the ADR process.

Sincerely,

The Alliance of Community Medical and Rehabilitation Providers