

Ontario Psychological Association

The Ontario Psychological Association's (OPA) Response to July 2014 Survey Questions from KPMG re: Ontario Ministry of Finance's Automobile Insurance Transparency and Accountability Expert Report

Respectfully Submitted to:
Mr. Houston Cheng
KPMG Adelaide Centre
333 Bay Street, Suite 4600
Toronto, Ontario M5H 2S5

Contacts:

Ms. M. Janet Kasperski RN, MHSc, CHE
Chief Executive Officer, OPA

Dr. Ronald and Faith Kaplan
Co-Chairs, OPA's Auto Insurance Subcommittee
21 St. Clair East, Suite 304
Toronto, Ontario M4T 1L8



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Executive Summary and Key Recommendations

Background

Since 2003, the Liberal Government has demonstrated great leadership in building awareness of mental health issues and improving access to mental health services. Premier Kathleen Wynne was re-elected in part on her renewed commitment to the *Ontario Mental Health and Addictions Strategy*.

The Government's commitment addresses the reality that people with developmental and acquired brain injuries and mental disorders lack timely access to necessary mental health services.¹ The result is personal and family suffering, disability and, all too frequently, mortality. The far-reaching costs for society and our provincial health care system add a dimension of urgency that is driving change in the system.

Early intervention saves money in the long term. The research is clear: if injured people receive a comprehensive assessment leading to an accurate diagnosis and timely access to the right services then their short-term and especially their long-term health outcomes are much more positive. The realization that any delay along the diagnostic to treatment and recovery pathway is a lost opportunity needs to be embedded in the minds of all stakeholders.

Limits on patient access to mental health services put greater strain on other resources in our health care system and the educational and justice sectors, and increase costs to governments at all levels.

How psychology helps

Psychologists provide critically important and evidence-based services for comprehensive assessments and the correct treatment of brain injuries and mental disorders anchored in an accurate diagnosis.

The OPA perspective

The OPA is a voluntary organization that represents the profession of psychology in Ontario and drives high quality, evidence-based practices forward in psychology and in mental health services in general. Our members are researchers, educators and clinicians who provide psychological services in their own private offices and clinics, in primary care practices, in hospitals, long term care facilities, correctional institutes, schools, colleges and universities and in various workplaces.

The OPA Auto Insurance Committee is tasked with providing information regarding auto insurance matters as they relate to accident victims with mental disorders and brain injuries (refer to as "mental disorders") to our Members and other health care disciplines, as well as to government, the insurance industry and other stakeholders.

¹ *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians* (August 2010), Final Report of the Select Committee on Mental Health and Addictions.



The Committee members appreciate the request for feedback and the opportunity to present important observations that were not considered in the interim report. It should be noted that the Committee had limited resources to respond to the survey questions. For example, we have not yet obtained the most recent GISA data or various insurers' financial statements. The Committee, therefore, relied upon the publically available HCAI data reports and feedback reported by our Members and other health care providers. As well, we did not have the resources to hire an independent actuary to analyze the previously distributed GISA data in comparison with insurers' financial statements and the FSCO benchmark data. In addition, the short time frame (over the summer holiday) for response to the survey precludes conducting a more formal and comprehensive survey of our Members.

Many of the survey questions state, "How have you or your members been affected by...". In this document, the OPA will provide information as it relates to the experience of our Members. In addition, we will include feedback from our Members about how accident victims with mental disorders and brain injuries have been affected by the issues under discussion.

The focus of the questions appears to be on various measures to reduce accident claims costs. The OPA contends that this is an inappropriately narrow perspective. Our feedback from psychologists regarding accident victims' experiences has identified significant harm that has occurred as a result of some cost reduction measures. Moreover, they described how some patients have been affected by the way in which some insurers are implementing cost reduction measures. Cost reduction measures have had negative and unintended consequences for some of the most vulnerable accident victims – those with mental disorders and brain injuries – and off-loaded the costs to public payers and to the victims and their family members.

Solutions to cost and premium reduction and improved access to mental health services

The OPA fully supports action to reduce auto insurance costs and premiums. We agree with the interim report that, "Insurers have an important role in helping the Government meet the average rate reduction target." (p. 54)

Where we disagree is the interim report's acceptance of the insurance industry's argument that further reductions in accident benefits (euphemistically described in the report as "modifying the Ontario automobile insurance product") are required in order to achieve the mandated 15% reduction in premiums. The industry appears to presume that other expenses of the insurance companies are "fixed" and has few expectations to achieve greater efficiencies in these other areas. Even though the interim report makes passing reference to how insurances might "gain efficiencies," it asserts that to sustain a permissible claim ratio of 69% further cost savings must come from reductions in benefits and payments to accident victims. There was little emphasis on exploring ways that companies could reduce other costs to achieve the necessary ratios.

1. In contrast, we believe that the following solutions would both reduce costs and help relieve some of the strain on our health care resources. More importantly, they would minimize the risk of harm to accident victims with brain injuries and mental disorders by providing greater access to mental health services. We urge that the following recommendations be implemented prior to any reduction in accident benefits:



- Implement a health provider licensing regime to create a mechanism to address fraud and inappropriate billing practices. Such a mechanism has been lacking for those providers who are not **regulated** health professionals;
- Address the excessive costs of towing and storage;
- Target accident prevention and injury reduction;
- Utilize telematics to reduce individual premiums for safe drivers and reinforce safe driving;
- Reduce cost drivers within the insurance industry so that a greater proportion of premium dollars go directly to accident victims for treatment and compensation for loss;
- Improve insurance companies' internal claims adjudication practices; and,
- Implement strategies to improve timely access to high quality, evidence-based services for accident victims with mental disorders.

Licensing of health provider facilities

The OPA welcomes the opportunity for greater involvement in the development and implementation of the licensing system.

To reduce the potential for unintended negative consequences, the OPA recommends:

- Creation of a limited exemption from the licence fee for clinicians who have received payment in the previous calendar year for a small number of claimants. (Many of these claimants practice in rural communities or have linguistic, cultural or other highly specialized areas of expertise). This accommodation would not significantly interfere with cost recovery within the overall licensing model or its anti-fraud objectives.
- Development of due processes to be used for the protection against vexatious complaints and unreasonable removal of licensed status.
- Direct and timely payment to all licensed health professionals by all insurers.
- Funding of relevant continuing education opportunities for all who are licensed.

Address the excessive costs of towing and storage

The OPA strongly agrees that these should be vigorously addressed. As health professionals, we hear complaints from patients regarding the costs involved. There also are reports that the same facilities are linked to other areas of abuse.

Target accident prevention and injury reduction

Compared to provinces with public auto insurance, Ontario (with a private auto insurance system) lacks the structure and incentives to invest in accident prevention. In British Columbia, for example, if an intersection is the location of a disproportionate number of accidents, the cause is addressed. The benefits accrue immediately as the number of accidents and claims costs are reduced. Similarly, we are aware of proposals from public health authorities to reduce speed on residential streets in proximity to schools to reduce injuries to child pedestrians. Making all



streets safe for children, seniors and bicycle riders should be a major goal as governments at the local, regional and provincial levels explore ways to align interests in Ontario and create a greater focus on accident prevention and injury reduction.

Utilize telemetrics to reduce individual premiums for safe drivers and reinforce safe driving

Telemetrics offer an opportunity to better determine individual insurance premiums based on driving behaviour. Importantly, they provide immediate feedback information to the driver to reinforce safer driving, resulting in fewer accidents and injuries. Thus, increased use of the telemetrics, and the incentives associated with their use, hold promise of reduced and/or more equitable premiums for the individual, fewer injuries, and reduced overall costs for insurers and government, in general.

Reduce non-accident benefit cost drivers within the insurance industry

The available cost data reveal a consistent pattern over time in which a reduced percentage of total funds are being paid to accident victims through accident benefits. At the same time, commissions, general expenses, and profits eat up an increased proportion of each premium dollar. These should be addressed as they account for approximately one-third of the costs in the system and offer opportunity for significant savings. Significant variability in these areas across insurance companies suggests that some have found opportunities for cost savings. The identification and sharing of “best practices” amongst more efficient insurance companies and potentially “coaching teams” should be important tools in creating an even playing field amongst the insurers.

Improve insurance companies’ internal claims adjudication practices

Adjudication practices vary greatly across companies even though they are operating within the same regulations. While some companies have relatively fair and efficient processes, others are highly inefficient and generate needless delays and costs. Still others disregard evidence-based treatment guidelines and take an overtly adversarial position with any claimant whose injuries are less visible, such as those with mental disorders. These practices contribute to higher levels of distress in already injured patients. Additional distress, combined with delays in provision of care, lead to increased disability and treatment costs, and subsequent higher levels of dispute, litigation, and settlement costs.

Implement strategies to improve access to services for accident victims with mental disorders

We support the implementation of the following strategies to improve access to services for accident victims suffering from mental disorders:

- Education regarding the nature of mental disorders must be improved. The aim of an education program would be to reduce discrimination and to overcome the continued narrow focus on severity of physical injury as a proxy for mental injury. All stakeholders need to understand that the “mental injury” is, frequently, the more serious and life altering injury.



- Standards must be created for proper adjudication, including consideration of the relevant evidence-based guidelines regarding assessment and treatment of mental disorders when making decisions.
- Insurers should require insurer examiners to have appropriate training and expertise, and to utilize a professional peer reviewer whenever appropriate. Given their higher levels of knowledge and skills, psychologists should be used to assess and diagnose mental disorders, comment on reasonable and necessary treatment, and the resultant disability.
- Psychologists must be allowed to certify applications for catastrophic impairment determination and to be relied upon as the sole expert to adduce evidence regarding mental disorders in tort-based legal actions under the Insurance Act.

Key Recommendations

1. Reduce barriers to necessary psychological services for accident victims with mental disorders;
2. Continue to acknowledge that mental disorders are not “minor injuries”;
3. Do not discriminate against those with impairments due to mental disorders; reject proposals from some parties to make the threshold for catastrophic mental impairment determination more stringent than for those with impairments due to physical disorders;
4. Reinstate provisions to reflect expertise and competence of psychologists by allowing them to conduct assessments and examinations and certify applications for catastrophic impairment determination due to mental disorder;
5. Do not reduce the supply of psychological treatment providers by imposing disproportionate licensing fees on psychologists who only treat a few patients under auto insurance. Provide a limited exemption from licensing fees for these regulated health professionals; and,
6. Reinstate the right of an accident victim who suffers permanent serious impairment of an important mental or psychological function to rely in court solely on evidence from a psychologist with appropriate expertise.



1.0 Questions 1 and 2

Questions 1 and 2: How have you or your members been affected by the auto insurance reforms that were introduced in September 2010?

1.1 Discussion

A large number of changes were introduced in 2010, many with the expressed intention to reduce accident benefit costs. In addition to limitations on housekeeping and attendant care benefits, these changes included:

- Minor Injury Definition and \$3500 cap on funding;
- Standard benefits reduced to \$50,000 including provider initiated assessments;
- Requirement that physician “conduct” the assessment and certify catastrophic the impairment application;
- \$2000 cap on fees for assessments and examinations;
- Removal of mandatory Insurer Examinations (IE) to deny treatment plans;
- Removal of requirement that insurers pay for “rebuttal assessments”;
- Removal of funding for IE reviewer to speak with treatment plan proposer; and,
- Required use of the Health Claims for Auto Insurance (HCAI) system

The available data confirm that these measures have resulted in drastic reductions in accident benefits. Psychologists report that many insurers are not making appropriate use of these provisions and/or are misusing them. In addition to looking at cost savings, it is also important to consider the negative consequences of the changes and their implementation for accident victims with mental disorders, as well as the resultant off-setting of costs of care of some of the most vulnerable accident victims to OHIP, other public services and to the victims and their families.

1.2 Objective

The OPA fully agrees with the objective of the 2010 reforms of reducing auto insurance costs and premiums. As was stated in the interim report, there has been drastic reduction in the amount spent on accident benefits. The report states:

A total of 69% of the industry provided estimates of the change to accident benefit (AB) claim costs as a result of the Reforms. On average, these insurers' most recent estimates of the impact would indicate a decrease of about 51% on AB disability income (AB-DI) claim costs, a decrease of about 39% on AB other than disability income (AB-Non DI) claim costs, and a decrease of about 46% on the claim costs for AB in total.

It is our objective to consider how these costs reductions can be maintained/increased while improving access to treatment and care for Ontarians who need mental health services.

1.3 The main issue

Auto insurance costs and premiums in Ontario are too high. Unfortunately, attempts to reduce costs are adversely affecting accident victims with brain injuries and mental disorders. The



result will be increased harm to individuals and their families, as well as greater strain on the public health care system and increased cost to government. Auto insurance costs need to be reduced in a way that does not compromise access to mental health services.

1.4 A balanced approach

Ontarians should not have to choose between lower premiums and timely access to mental health services. The OPA is committed to working with Government, FSCO, and other stakeholders to reduce auto insurance costs. It is an imperative that the actions we take together protect access to care and minimize the risk of harm to vulnerable accident victims with brain injuries and mental disorders.

1.5 No-fault benefits and mental health

No-fault accident benefits were introduced to provide timely access to treatment and rehabilitation for those injured in auto accidents. In addition, no-fault benefits help to avoid the shifting of costs and demand for services to the already strained public health care system.

In recent years, however, access to no-fault benefits for accident victims with brain injuries and mental disorders has been reduced. These restrictions act as significant barriers to proper assessments, accurate diagnoses and treatment. Moreover, they impose additional costs on accident victims and our health care system. Further, they are contrary to the Government's leadership in increasing awareness of mental health issues and improving access to mental health services. Finally, these restrictions fail to recognize the significant expertise and relative cost-effectiveness of psychologists in these matters.

1.6 Minor injury definition and \$3500 cap on funding

The introduction of the minor injury definition, with the associated \$3500 cap on funding for goods and services, was a fundamental shift in the model of accident benefits, introducing a "meat chart" approach. It was premised on a predetermined lower cap for goods and services based on the nature of the injury rather than providing funding for the goods and services that are reasonable and necessary to reduce impairments and restore function of the individual person within the standard benefit funding limits. In addition, individually based treatment plans are replaced with the presumption that all persons with minor injuries (with very limited exceptions) will be treated within the Minor Injury Guideline (MIG).

The SABS provide the following regarding "minor injury":

"Minor Injury" means one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury; ("blessure légère")

"Minor Injury Guideline" means a guideline:

that is issued by the Superintendent under subsection 268.3 (1.1) of the Act and published in The Ontario Gazette; and, that establishes a treatment framework in respect of one or more minor injuries ("Directive sur les blessures légères").

Monetary limits re medical and rehabilitation benefits:



The sum of the medical and rehabilitation benefits payable in respect of an insured person who sustains an impairment that is predominantly a minor injury shall not exceed \$3,500 for any one accident, less the sum of all amounts paid in respect of the insured person in accordance with the Minor Injury Guideline. O. Reg. 34/10, s. 18 (1).

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 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. O. Reg. 34/10, s. 18 (2).

Distinguishing psychosocial issues treated within the MIG from psychological disorders, which are not minor injuries, was addressed in detail in the OPA submission for the Three Year Review and the OPA response to the FSCO draft statement of priorities. Classifying mental disorders as “minor injuries” will cause further harm to this already vulnerable subset of accident victims.

Patients with brain injuries and mental disorders now face additional delays and barriers in their ability to access treatment under the no fault benefits due to the misapplication of the minor injury definition.

Psychologists report an almost universal presumption by insurance adjusters that the existence and severity of mental disorders are determined by the nature of the physical injuries. As a result, virtually all applications for psychological assessment/treatment for an accident victim whose physical injuries appear to fall into the minor injury definition are denied. Psychologists report these denials occur even when the patient is referred for psychological services by their family physician or medical specialist, and a comprehensive and clinically appropriate screening (in keeping with OPA evidenced- based guidelines) has been completed documenting the indicators for the proposed services. It is well documented that due to continuing stigma, most individuals are reluctant to acknowledge mental disorders and seek psychological treatment. When faced with a denial from their insurer, they give up seeking psychological services, leading to prolonged disorders and further reductions in function.

Psychologists report positive results for those patients who were able to persist in the process, if the initial screening is properly conducted. In those cases where the insurer has obtained an Insurer Examination (IE), the conclusion of the IE generally concurs that there was a predominant mental disorder, the minor injury definition was not applicable and there was a need for psychological services. Even when the IE results in the insurer’s reversal of their denial of the proposed services, the denial and review process, however, caused additional delays and stress for the patient accessing services and needless costs to the system.

There are several strategies to improve access to services for accident victims with mental disorders and reduce harm caused by inappropriate application of the minor injury definition. These include:

- Continue to acknowledge that mental disorders are not “minor injuries”;



- Improve education regarding the nature of mental disorders, with the aim of reducing discrimination and overcoming the continued narrow focus on severity of physical injury as a proxy for mental injury;
- Create standards for proper adjudication, including consideration of the relevant evidence-based guidelines regarding assessment and treatment of mental disorders when making decisions; and,
- Require insurer examiners to have appropriate training and expertise, utilize a professional peer reviewer whenever appropriate and rely upon psychologists to undertake a comprehensive assessment, provide an accurate diagnosis of mental disorders and comment on reasonable and necessary treatment, and resultant disability.

See Appendix for full discussion.

1.7 Standard benefits reduced to \$50,000 including provider initiated assessments

Psychologists report that, with the reduction in the standard benefit level from \$100,000 to \$50,000, there is now a significant problem for a subset of patients with serious injuries. The \$50,000 accident benefit limit is insufficient for some patients to obtain reasonable and necessary treatment to reduce impairment and restore function.

Further, the standard benefit limit of \$50,000 is actually much lower than stated. The costs of assessments completed on behalf of the insured person that were formerly in addition to the \$100,000 policy limit are now also included in the benefit limit. Psychologists report spending significant amounts time working with their patients to determine how to best ration the available funds and how to choose which of the required services they will forego, in addition to providing needed services.

When patients with serious injuries, including mental disorders, run out of accident benefits, their rehabilitation and recovery are limited, since many of the needed services are not available in the public health system as noted above. Where the services are available, there are often significant delays. Shifting of costs to the public health and other systems simply increases access delays to an already underserved sector.

We note that even for that very small minority of accident victims who may ultimately be determined to have a catastrophic impairment, the funding shortfall is likely to occur prior to the time frame for application and determination to access the higher level of funding. Time delays means lost opportunities for rehabilitation and increased long-term costs.

1.8 Requirement that physician “conduct” the assessment and certify the catastrophic impairment application

The legal requirement that only a physician – not a psychologist – may conduct an examination or assessment and certify the application to determine the existence of catastrophic impairment (except, in very limited circumstances, a neuropsychologist) creates an arbitrary barrier to catastrophic applications for patients with mental disorders and adds unnecessary costs to the



system.² In fact, psychologists, who are one of the only two professions authorized to communicate a diagnosis of a mental disorder, are often better placed and have more expertise to conduct these assessments. Prior to 2010, psychologists were permitted to conduct these assessments and certify catastrophic impairment applications. There has never been any reasonable explanation for the decision to remove psychologists from this role that they are fully equipped and able to fulfil.

This interference with patient access and source of needless additional transaction costs could be remedied by reinstating the provisions to reflect expertise and competence of psychologists by allowing them to conduct assessments and examinations and certify applications for catastrophic impairment determination due to mental disorder.

1.9 \$2000 cap on fees for assessments and examinations

A \$2000 cap on the fee for any one assessment or examination was introduced to address the proportion of funds being spent on transaction costs including assessments required to propose or dispute benefit applications. A system which requires an application for prior approval and payer review of the application, inevitably, will have transaction costs in order to determine which applications are appropriate. Assessments to complete applications and insurer reviews are needed for a variety of purposes including: disability determination, catastrophic impairment determination, attendant care, as well as for medical and rehabilitation benefits. A reasonable benchmark for total cost for these assessments is not known at this time but needs to be established.

Regarding medical and rehabilitation benefits, the requirement in the no-fault accident benefit system of prior application and insurer review differs from the OHIP system wherein there is no requirement for prior approval of paid services. It also differs from the WSIB system in that under auto, the causal role of the MVA must also be addressed in the assessments.

Feedback from psychologists and other health professionals indicated that the fee cap has drastically reduced the cost per assessment completed by both proposing health professionals and by IE reviewers. They reported significant reductions in the fees paid to health professionals for the assessments and the subsequent use of less experienced providers. As well, they reported expectations for more limited assessments and reports that are not in keeping with best practices and professional standards. They also reported change in some practices, for example, utilizing local providers, rather than paying for an expert to travel to complete an assessment.

While we agree that it is appropriate to impose reasonable limits on assessment fees, the fee cap does not allow for exceptions which may require more rigorous, extensive assessments, or in which it is necessary for the expert to travel to an underserved area. We also note that some insurers are misapplying the guideline, and asserting that the \$200 form fee is within the fee cap and that all assessments completed by each health care professional, in combination, must not exceed the \$2000 fee cap. This is inconsistent with the regulation that provides the cap is applied to any one assessment or examination. Dealing with these issues leads to needless delays, lost early interventional opportunities, disputes and associated costs. These inappropriate insurer behaviours create a barrier to accident victims' ability to access appropriate assessments to

² O. Reg. 34/10, subs. 45(2).



complete benefit applications, create delays, disputes and needless costs to the system, and should be addressed.

1.10 Removal of mandatory Insurer Examinations (IE) to deny treatment plans

In addition to the assessment fee cap, the requirement of an IE prior to denial of a benefit application was removed. The OPA agrees that it is reasonable that the insurer has discretion and be able to rely on a previously conducted timely, relevant IE as the basis of the reason for denial of an application. However, psychologists reported that insurers, most frequently, deny applications without citing any “medical reason” or other reason, simply stating that the proposal is “not reasonable and necessary”. In addition, psychologists reported that insurers often rely on out of date or inappropriate IEs as the basis to deny an application. For example, they may rely on a physical examination IE to assert that there is no mental disorder where this was not addressed in the IE or rely on an IE that is a year old to comment on whether there is a current mental disorder. Again, these inappropriate insurer behaviours create a barrier to accident victims’ ability to access appropriate assessments to complete benefit applications, create delays, disputes and needless costs to the system, and should be addressed.

1.11 Removal of requirement that insurers pay for “rebuttal assessments”

Prior to the 2010 regulation changes, if an insured person disagreed with an insurer’s denial of an application based on an Insurer Examination, the insurer was obligated to pay reasonable costs of a “rebuttal” assessment from the expert of the insured person’s choice to address the disagreement. Since the insurer is not obligated to pay for any services that they have denied pending further dispute resolution, the ability to access these rebuttal assessments provided some balance to the system. These rebuttal assessments served a variety of functions. If the assessment supported the insurer’s denial, it often satisfied the patient and avoided further dispute. If the assessment identified some omission or error in the Insurer Examination, the insurer would often change their position, providing timely access to the benefit for the insured person and avoiding additional dispute. Further, these rebuttal assessments were utilized in dispute resolution when they did not result in an earlier resolution. Since this provision was removed, psychologists have reported that their patients now have a greater need to utilize legal assistance to address an Insurer Examination that is fundamentally flawed or based on incorrect information. Individuals without such resources are, therefore, unreasonably denied access to services. This imbalance should be corrected.

1.12 Removal of funding for IE reviewer to speak with treatment plan proposer

The removal of funding for the IE reviewer to speak with the treatment plan proposer has contributed to a more adversarial situation and greater polarization between IE reviewers and treatment providers, and results in needless and prolonged disputes. Perhaps if the IE reviewer conducted a brief conversation with the treatment plan proposer, issues could be clarified and agreement on the disputed treatment could be achieved, thus providing more timely access to services and reducing the costs associated with needless delays and disputes. Explicit funding for this communication should be reinstated.



1.13 Required use of the Health Claims for Auto Insurance (HCAI) system

The OPA supports the requirement that Health facilities bill the auto insurer for services to utilize the Health Claims for Auto Insurance System. In addition to creation of a common database of some of the costs of the auto insurance system, the HCAI electronic submission system provides an opportunity for insurance companies to increase the efficiency of their claims adjudication and invoice review and payment processes.

The HCAI process requires all facilities to provide complete information in a standardized format utilizing a common coding system for injuries and interventions. The HCAI submission system itself assures that only properly completed applications and invoices accepted by HCAI will flow through to the insurer, allowing for more systematic procedures. This should have provide major improvements compared to the previous system when there was no control over the completeness of paper forms that were submitted. This coding should allow more automated and systematic matching of interventions to diagnosis and the identification of treatment plans that warrant further review. When the system was first introduced, it was hoped that the potential for more automated adjudication would allow for more rapid review of treatment plan, including on-line adjudication in real time. Unfortunately, the reverse has occurred and the time lines for review of treatment plans have increased.

Regarding adjudication of invoices, approved treatment plans are assigned a number and this number appears on the corresponding invoice. This process should make invoice review and payment a far more efficient process. In addition, to further assist insurers' ability to review invoices, service providers have been restricted to submitting invoices once every 30 days. This limitation may interfere with usual and customary billing practices (for example billing at the time of provision of each service) and leads to further delays in receipt of payment. (This delay is made more significant by the requirement that the provider must first bill the extended health benefits provider and wait to receive payment and/or explanation of benefits for non- or partial payment prior to billing the auto insurer. The provider has no control over when this is received.) The restriction to bill only once every 30 days has substantially reduced the number of invoices to be processed by the insurer. Unfortunately, psychologists have not observed a corresponding reduction in delays or improvement in accuracy of invoice payment. Psychologists report significant delays in the approval of submitted invoices and delays in receipt of payment for approved invoices, as well as refusal to pay interest on overdue accounts. These insurer practices are contrary to the regulations and should be addressed.

Psychologists report great variability among companies. Some insurers do not seem to utilize the technological possibilities of the electronic submission system. For example, some companies report that they treat the HCAI system as "if it as a fax machine" and print off the documents to be processed as if they were received in a paper based system. Similarly, some report that they do not have an automated way to match the invoice to the corresponding treatment plan.

Health professionals have invested time and money to bring their administrative practices for submission of treatment plans and invoices into compliance with the requirements of the HCAI system. It does not appear, however, that insurers are making full use of this system and thus are not achieving the efficiencies and cost savings that it could provide. Addressing this area would provide cost savings to insurers that could contribute to premium reductions without further harm to accident victims' ability to access services.



2.0 Questions 3, 4 and 5

Questions 3, 4, and 5 regarding the recommendations made by the Anti-Fraud Task Force in November 2012.

2.1 Discussion

The OPA applauded the July 23 announcement of convictions against major fraud rings for creating staged accidents and health facility misrepresentation in billings as an important step in addressing fraud in the system.

The announcement also indicated that some health professionals were victims of these fraud rings. Their professional credentials were used to bill for services even though they were no longer working in the facility. At this time, there is only a pilot project allowing some health professionals to identify which facilities include them on their rosters. There is no way in real time for the health professionals to check for billing that is done in their name to verify its accuracy. The pilot project needs to be expanded to include this functionality and ongoing access. The OPA supports initiatives to further address and reduce these activities in order that funds be spent to provide necessary services to legitimate accident victims.

A number of the anti-fraud recommendations that are consistent with sound business practices were brought into Regulation and incorporated into the list of Unfair or Deceptive Acts and Practices. The OPA notes that many of these were already addressed by the College of Psychologists' expectations regarding appropriate professional business and billing practices. As such, they have not resulted in change in practice for most psychologists but may have led to greater changes in practice for non-regulated service providers. In addition, the Regulations now provide a separate mechanism to support and enforce these expectations in addition to the College complaint process.

A number of changes came into force on June 1st, 2013. They were announced in FSCO Bulletin No. A-01/13. It appears that some insurers are not yet making full use of these tools to address potentially fraudulent behaviour. These changes include:

- Requiring insurers to provide all reasons when denying claims;
- Providing FSCO with authority to stipulate additional information that insurers need to provide;
- Providing bi-monthly benefit statements to claimants;
- Giving insurers authority to require claimant confirmation of receipt of goods and services that have been billed;
- Providing FSCO with authority to stipulate by Guidelines, the maximum payable by insurers for goods, as well as services;
- Changing the UDAP regulation include an offence to request, require or permit a claimant to sign an incomplete claim form; and,
- Licensing of Health Facilities that bill the auto insurers.



2.2 Requiring insurers to provide all reasons when denying claims

The OPA recognizes that proper adjudication of applications will both contribute to consumer protection and assist to reduce fraud by identifying those applications/claimants that appear to warrant further scrutiny. Sound adjudication should allow insurers to provide “all reasons” when denying a claim. Unfortunately, there is an almost universal failure of insurers to comply with this requirement. Psychologists reported that most denials only state that the application is “not reasonable and necessary” without providing any reason. This unreasoned approach leads to unwarranted denials that interfere with the injured person’s ability to receive necessary services for their recovery. In addition, an unwarranted denial, even if followed by an Insurer Examination that approves the treatment, causes delays and unnecessary stress, often worsening the condition and increasing transaction costs. Enforcement of the requirement for the insurer to provide reasons would contribute to both consumer protection and identification of potentially fraudulent behaviour that requires further investigation.

2.3 Providing FSCO with authority to stipulate additional information that insurers must provide in bi-monthly benefit statements to claimants

We support that a timely, comprehensive, detailed statement of expenses would contribute to identification and elimination of fraudulent billing by service providers. This would allow the insured person to identify whether the insurer was being billed for services that they had not received so that any discrepancies could be addressed. Insured persons would be in a better position to monitor how their accident benefits are spent. Insureds could also monitor how much insurers are spending on insurer examinations. However, many insurers do not appear to be fulfilling this obligation. Psychologists report being told by many patients that they do not receive any statements. Those that receive statements report that they do not provide sufficient detail to understand the expenses. Enforcement of the requirement for the insurer to provide appropriate and timely benefit statements would contribute to fraud reduction.

2.4 Giving insurers authority to require claimant confirmation of receipt of goods and services that have been billed

Psychologists report rare instances of being informed that the insurer has sought confirmation of receipt of goods and services that have been billed. This may indicate that the insurers are appropriately using this authority in a selective manner and targeting those instances where there is a basis to suspect that services that have been billed have not in fact been provided. Alternatively it is possible that insurers are not making sufficient use of this authority. Further information regarding the effectiveness and cost/benefit analysis of this provision is required.

2.5 Providing FSCO with authority to stipulate by Guideline the maximum payable by insurers for goods as well as services.

It had been previously identified that some service providers were billing auto insurers more for various goods than the price at which these same goods can usually be purchased. The OPA does not know the extent to which this is an issue. We support, however, the fact that it is appropriate that goods provided by service providers be reasonably priced. We do not know if this authority is being used on a routine basis to review the costs of goods that are commonly prescribed and to address any inappropriate billing practices.



2.6 Changing the UDAP regulation to include an offence to request, require or permit a claimant to sign an incomplete claim form

Informed patient consent is a cornerstone of sound clinical practice and a requirement of the College of Psychologists. In addition to a verbal detailed and patient-specific informed consent, the opportunity to review and provide a signature on the claim form provides further documentation of informed consent to the proposed application. The prohibition on signing blank forms will help to address those unregulated and other service providers who may have engaged in this practice. The OPA would welcome information regarding the enforcement of this UDAP regulation.

2.7 Licensing of health facilities that bill the auto insurer

A process to license all facilities that bill the auto insurer is now in the implementation stage. Psychologists have commented that licensing would be most relevant for service providers whose business practices are not regulated already by a health professional college (i.e., businesses operated by unregulated health care professionals). The government has determined, however, that it is most appropriate to regulate all providers. The OPA is supportive of the initiative and believes it will assist in eliminating fraudulent facilities from the system. We have specific concerns and recommendations to improve the application that will, in particular, avoid creating problems of patient access to providers. (See above for recommendations regarding licensing)

The OPA has noted that the full cost of the licensing program is being born by the health facilities. The fee structure is based on a “cost recovery” model with none of the costs being assumed by the insurers or the government. It is not yet possible to quantify what the cost of this system will be for our members. It is clear that these added costs will have the equivalent effect of a reduction in the hourly fee. Unfortunately, the hourly fee has not been raised in the past several years and is still significantly below its 2001 level. Since these costs will reduce the fee even further, concern is being expressed about that many professionals may withdraw from the provision of services for injured Ontarians.

3.0 Questions 6, 7, and 8

Questions 6 through 8: regarding “recommendations regarding systemic causes of and solutions to the mediation backlog, potential changes to current structure, delivery model and process, the addition of a dispute prevention process for the system and other issues related to the viability of the DRS” released by Justice Douglas Cunningham February 2014.

3.1 Dispute Resolution System: Qualitative assessment

How have you or your members been affected by the Ontario automobile Dispute Resolution System? Would it be possible to provide a qualitative assessment?

Psychologists reported that for many of their patients the dispute resolution system did not provide a sufficiently timely mechanism to address denied treatment plans. Historically, when



the mediation backlog was prolonged, and mediation was required prior to proceeding to arbitration, an insured person would have virtually no real remedy to challenge a denied treatment plan. Often by the time the matter proceeded to arbitration, the patient's disorder had worsened. The proposed treatment was likely to be less effective than it would have been when the condition was less chronic and there were fewer secondary problems. When the process was excessively long, it appeared that many patients became thoroughly discouraged and gave up on the process. It also appeared that these delays actually encouraged the insurer to deny plans without sound basis since there was a strong likelihood that the denial would never be challenged in arbitration. Thus, in many ways the delays may have in fact contributed to excessive and unreasonable denials that in turn contributed to further delays.

The OPA recognizes that the mediation backlog has now been addressed. We would appreciate an opportunity to see any data that would help us to understand if the elimination of the mediation back log has led to a more timely mechanism to address disputes regarding treatment plans and if there is any corresponding change in insurer patterns of responses to treatment plans.

Psychologists also reported that within our current dispute resolution system their patients with mental disorders are unreasonably disadvantaged in the ability to put forward a Tort claim by the requirement that, in addition to any other evidence, evidence be adduced from a physician. In non-auto insurance matters, physician evidence is not required; the court and the parties determine the appropriate experts to utilize. This requirement fails to acknowledge that a psychologist may be the health professional with the most appropriate expertise (psychologists are one of only two professions authorized to communicate a diagnosis of a mental disorder) and in the best position to provide the necessary assessment and report for the court. The additional requirement of a physician to adduce evidence adds a barrier to the patient since there is a very limited supply of physician experts in mental disorders. We note that there is an under-supply of psychiatrists in most areas and that there are long waiting lists for most psychiatrists to be seen for clinical treatment. This requirement adds unnecessary costs to the system as well as a barrier to patients and should be removed.

3.2 The impact of the Dispute Resolution System on members

Have you analyzed the impact of the Ontario automobile Dispute Resolution System on your members? If so, would you be prepared to discuss your findings? Would it be possible to provide the results of such quantification?

We do not have data available to produce a quantitative analysis. The OPA would welcome the opportunity to review data regarding outcomes of disputes regarding treatment plans.

3.3 The impact of the Justice Cunningham Report

How will you or your members be affected by the recommendations in Justice Cunningham report? Would it be possible to provide a qualitative assessment?

Many of the implications of the recommended changes in the dispute resolution system for the patients of psychologists with mental disorders will depend on the specific details of the new



system. The OPA understands this will be a subject of regulations that have not been developed to date. While we support the principle of more timely/efficient access to dispute resolution, especially for treatment plans, we are concerned if some of the other proposals will have the effect of limiting the insured person's access to dispute resolution. Given the power imbalance between the accident victim and the insurer, it is inappropriate to create any additional barriers to their ability to challenge an insurer's decision.

4.0 Questions 9, 10, 11, 12 and 13

Questions 9-13: As part of the 2013 Ontario Budget, Government initiated the Auto Insurance Cost and Rate Reduction Strategy.

4.1 Discussion

The OPA has noted that these questions focus narrowly on reduction of costs and premiums. We agree with the goal of cost and premium reductions. As noted previously, however, actions taken to reduce costs and premiums must not undermine the purposes of auto insurance, that is, the restoration of function and compensation for loss. Some of the changes intended to reduce costs (or the way in which insurers have implemented them) have harmed accident victims with mental disorders and in some cases, have actually contributed to increased costs within the auto insurance system as well as the offset of costs to OHIP and other public systems.

4.2 Steps taken by our members to reduce costs

What steps have you or your members already taken to reduce costs that would affect the automobile insurance product?

As discussed previously, the series of changes to the accident benefit system since 2010 has resulted in drastic reductions in the amounts paid for accident benefits to injured accident victims. The hourly fee paid to psychologists is still lower than it was in 2001. In addition to this reduction in the hourly fee paid to psychologists, there has been the reduction in the amount of the standard benefits available to treat and rehabilitate our patients (\$50,000) and the restrictions of the \$2000 assessment fee cap. As an organization, we are providing guidance and support to ensure that our members are highly skilled and remain motivated to provide the best care possible under these circumstances.

The OPA continues to emphasise that the scientific literature supports the fact that timely provision of psychological treatment methods is effective in reducing impairments and restoring functionality. Moreover, early and appropriate psychological services reduce the costs of insures, health, government and personal expenses. To ensure that psychological services are available to our patients, psychologists have developed and updated evidenced based assessment and treatment guidelines to direct focused assessments and efficient/effective treatment. Psychologists are working as well, within the reduced funding model, to assist patients to make decisions about the most vital services available to them – decisions that a difficult for both our members and their patients.



In addition, psychologists are working together with other health professionals to support the implementation of the health facility licensing system to assist in addressing any facilities engaged in fraudulent billing practices.

4.3 Future cost reduction strategies

What are you or your members planning to do by mid 2015 to reduce costs that would affect the automobile insurance product?

Under the auspices of the Coalition of Regulated Health Professions, the OPA is working with other health care professionals to support the ongoing development of the HCAI data reports and anti-fraud initiatives. The Coalition is also working to foster the implementation of the FSCO health facility licensing program.

Psychologists are working on developing Guidelines for Insurer Examinations. The Guidelines will contribute to more confidence in the IE system and result in a reduction in disputes with associated delays and costs. In addition, the OPA is in the process of updating our assessment and treatment guidelines to provide direction to psychologists and insurers regarding the application of evidence-based assessment and treatment practices within the auto insurance context.

4.4 Cost reduction barriers

Could you identify any issues that would prevent you or your members from reducing costs that would affect the automobile insurance product?

Psychologists reported that patient conditions are often worsened and treatment is made less effective and more expensive by the delays and stress resulting from inappropriate, unreasonable insurer denials. In contrast, research confirms that provision of psychological treatment is cost effective. It not only reduces impairment and restores function, but reduces the utilization and costs of other health care services. Any so called “cost reduction initiative” that impacts negatively on access to assessment and treatment is a “cost driver” in the long term.

4.5 Recommended Government initiatives to reduce member costs

Are there any further actions that the Government can implement to help you or your members to reduce costs that would affect the automobile insurance product?

The OPA has identified a number of recommendations to government, discussed above, which would allow psychologists to contribute more effectively to both reduction of costs and provision of services. Our end goal is to reduce impairments and restore function of accident victims with mental disorders leading to long term cost reductions and higher quality of life for our patients.

The key recommendations are:

- Reduce barriers to necessary psychological services for accident victims with mental disorders;
- Continue to acknowledge that mental disorders are not “minor injuries”;



- Do not discriminate against those with impairments due to mental disorders; reject proposals from some parties to make the threshold for catastrophic mental impairment determination more stringent than for those with impairments due to physical disorders;
- Reinstate provisions to reflect expertise and competence of psychologists by allowing them to conduct assessments and examinations and certify applications for catastrophic impairment determination due to mental disorder;
- Do not reduce the supply of psychological treatment providers by imposing disproportionate licensing fees on psychologists who only treat a few patients under auto insurance. Provide a limited exemption from licensing fees for these regulated health professionals; and,
- Reinstate the right of an accident victim who suffers permanent serious impairment of an important mental or psychological function to rely in court solely on evidence from a psychologist with appropriate expertise.

4.6 Further actions

Are there any further actions that the other stakeholders can implement to help you or your members to reduce costs that would affect the automobile insurance product?

The OPA provided several recommendations that other stakeholders could implement that would reduce costs and improve access to services for those with mental disorders. These included:

- Utilize telemetrics to reduce individual premiums for safe drivers and reinforce safe driving;
- Reduce cost drivers within the insurance industry so that a greater proportion of premium dollars go directly to accident victims for treatment and compensation for loss;
- Improve insurance companies' internal claims adjudication practices;
- Improve education regarding the nature of mental disorders, with the aim of reducing discrimination and overcoming the continued narrow focus on severity of physical injury as a proxy for mental injury;
- Create standards for proper adjudication, including consideration of the relevant evidence-based guidelines regarding assessment and treatment of mental disorders when making decisions; and,
- Require insurer examiners to have appropriate training and expertise, and utilize a professional peer reviewer whenever appropriate and rely upon psychologists to diagnose mental disorders, comment on reasonable and necessary treatment, and resultant disability.



5.0 Miscellanea

5.1 Uncertainties

What uncertainties in the Ontario automobile insurance system are affecting you or your members?

The OPA has noted that the insurers cited in the interim report expressed concern regarding uncertainty in the system and claimed that they could not provide further premium reductions due to unpredictability in ultimate costs of claims. However, many of these assertions are inconsistent with available data. We note that that GISA data is based on “incurred costs” which we understand include future amounts that the insurers’ own actuaries have determined might be required to pay on a claim. We also note that there have been many extreme statements made in the media by insurers regarding the likely outcome of various arbitration decisions “undermining” the cost savings in the system. They have stated that the “flood gates would open” or there would be a “tsunami” of increased costs. However these dire predictions have not been born out over time. In fact, a variety of factors appear to have actually contributed to a pattern of continuing reductions.

5.2 Issues related to uncertainties

What issues do you or your members see as contributing to the uncertainty in the Ontario automobile insurance system?

Lack of data and shared information is the main contributor to uncertainty. The OPA questions how much real “uncertainty” exists as opposed to a perception of uncertainty based on anecdotal information and repeating of potential worst-case scenarios. The HCAI system has provided some helpful information regarding medical and rehabilitation utilization and cost. To further reduce uncertainty, we need to collect and share more information in this system that would be helpful to all stakeholders.

5.3 Impact of uncertainty on members

Have you analyzed the impact of the uncertainties in the Ontario automobile insurance system on your members? If so, would you be prepared to discuss your findings? Would it be possible to provide the results of such quantification?

The OPA has not had access to data to provide this analysis. We would welcome more complete data that would show cost trends in a manner that is transparent and available to all stakeholders.

5.4 Mitigation issues

Do you have any insight as to how these issues may be mitigated? Could you identify any action steps that could be taken to alleviate the uncertainty in the Ontario automobile insurance system?



More thorough HCAI data and publicly available standardized data regarding utilization and costs would help to identify trends and reduce uncertainty.

These additional data would include information regarding:

- The number of assessment/treatment plan applications, denials, IEs regarding med/rehab benefits and their outcomes;
- The number of applications, approvals, IEs and outcomes for disability and catastrophic determinations.
- The amounts paid for income replacement benefits.

Access to this information and other such data regarding the full costs of auto accident injuries would assist in system planning, continuous quality and system improvements and a reduction in provider uncertainty.

5.5 Insurance marketplace's competitiveness and efficiencies

Do you believe that the auto insurance marketplace in Ontario is sufficiently competitive and efficient in providing affordable premiums to consumers?

The OPA does not believe that the auto insurance marketplace in Ontario is sufficiently complete and efficient or that it provides affordable premiums to consumers. Psychologists reported that very few patients have ever had their broker volunteer information regarding optional benefits. Many brokers provide limited information when requested. Similarly, for renewals, few brokers initiate any sort of comparison of rates available through various providers. There are still questions regarding additional commissions paid by some insurers. We also question whether the consolidation of some companies will further reduce competition. We would welcome further work to foster greater focus on internal efficiencies and cost savings within the insurance companies, which could help to reduce costs and therefore premiums.

6.0 Appeal Decisions

Have you or your members been affected by the following recent appeal decisions?

6.1 Scarlett v. Belair?

Patients seen by psychologists often experience inappropriate and unreasonable denial of their applications for assessment and treatment of their mental disorders. The most common cause of the denial is the insurer's assertion that they have a minor injury based on the insurer's classification of their physical injury if it falls within the minor injury definition. (See fuller discussion previously presented and in the Appendix).

"Psycho-social" issues can be part of a minor injury presentation. These issues tend to be resolved rather easily and can be appropriately addressed within the Minor Injury Guideline. A patient presenting with a mental disorder, however, cannot be considered to have a "minor injury" that will resolve with little or no interventions.



The OPA is aware that some insurers report that they believe that the minor injury definition is “not holding”. Their perception that a great many “claimants will move outside of the minor injury limits” is simply not consistent with the available data.

The HCAI standard data report makes it clear that, even for the most mature claims, the proportion of accident victims that remain within the minor injury funding limit of \$3500 is very high. From our review of the HCAI standard data report we understand that approximately 70% remain within the minor injury fee cap. In addition, we noted there may be some confusion due to the nature of the coding. There is a group classified as “MIG+NON MIG”. These patients received some services in addition to the \$2200 MIG program that may or may not be within the minor injury cap. Due to the coding system, “NON MIG” includes an additional \$1300 of funding for services within the minor injury cap. The average cost for the MIG+NON MIG even in the most mature claims from the first half of 2011 is confirming that the vast majority have remained within the minor injury cap.

6.2 Pastore v. Aviva?

When this decision was announced, there were assertions by insurers that there would be an “erosion of the catastrophic impairment definition”. The fear was expressed that the “floodgates” would be opened and that anyone could be determined to have a catastrophic impairment with access to the higher level of benefits. It was used to justify pressure from the insurance industry to make the definition even more restrictive and to arbitrarily discriminate against those with mental disorders by making the criteria for their disorders more severe than those for physical disorders.

In fact, it is correct to assert that the criteria have not been eroded. The definition remains very stringent. As result, the criteria are still satisfied by only an extremely small subset of accident victims. The Pastore decision affirms that a person must have a marked impairment due to a mental or behavioural disorder in order to satisfy the catastrophic impairment criteria. This has not resulted in an increase in the very small number of individuals found to have a catastrophic impairment due to a mental disorder.

6.3 Henry v. Gore Mutual?

The OPA has noted that, subsequent to this decision, the government brought in the requirement regarding “incurred” expenses. Again in the interim report, the insurers are cited as expressing concern regarding possible erosion of regulation 347/13 due to greater use of “professional services”.

It was our understanding that the intention of the regulation regarding incurred expenses was to address possible inappropriate practices. It was claimed that some family members might be receiving compensation for services that were not actually being provided or that were not an actual expense. The OPA contends that there may have been more targeted ways to address this concern.

There are a very limited number of individuals who qualify for attendant care based on the severity of their needs. It seems mean spirited, and contrary to the purposes of insurance, to see turning to professional providers in these cases as problematic. It must also be stressed that all



attendant care services are subject to insurer approval. Insurers are able to control whether any services are provided and, if offered, how many hours of services are provided. The professional services guideline outlines hourly fees, as well as monthly and total maximums. The guidelines also limit the ability to engage professional services.

6.4 Other Comments

The OPA appreciates being asked for comments and would welcome the opportunity to discuss our observations and recommendations with the survey authors.

6.5 Confidentiality

Does your organization wish to remain anonymous in the 2014 Report as described in our cover letter?

We expect that these observations and recommendations will be publicly identified as submitted by the OPA.

7.0 Key Recommendations

- **Reduce barriers to necessary psychological services for accident victims with mental disorders;**
- **Continue to acknowledge that mental disorders are not “minor injuries”;**
- **Do not discriminate against those with impairments due to mental disorders; reject proposals from some parties to make the threshold for catastrophic mental impairment determination more stringent than for those with impairments due to physical disorders;**
- **Reinstate provisions to reflect expertise and competence of psychologists by allowing them to conduct assessments and examinations and certify applications for catastrophic impairment determination due to mental disorder;**
- **Do not reduce the supply of psychological treatment providers by imposing disproportionate licensing fees on psychologists who only treat a few patients under auto insurance. Provide a limited exemption from licensing fees for these regulated health professionals; and,**
- **Reinstate the right of an accident victim who suffers permanent serious impairment of an important mental or psychological function to rely in court solely on evidence from a psychologist with appropriate expertise.**



Appendix

Minor Injury Definition

Psychosocial Issues are appropriately addressed within the MIG

Some accident victims with minor physical injuries may also present with psychosocial issues (symptoms/complaints) which are appropriately considered within the Minor Injury (MI) cap and addressed within the Minor Injury Guideline (MIG). These issues and services are illustrated in the section on supplementary goods and services in the MIG, “*Supportive interventions such as advice/education to deal with accident-related psycho-social issues, such as but not limited to: distress; difficulties coping with the effects of his/her injury; driving problem/stress*”. However, the inclusion of psychosocial issues must not be inappropriately expanded and forestall the appropriate identification and treatment of accident victims’ mental and behavioural disorders. These disorders are not minor injuries. To the contrary, the literature is unequivocal that psychological disorders have greater adverse functional impact than do physical impairments. There is a risk of discriminating against those with less visible impairments due to mental and behavioural disorders. Patients with these disorders are subject to a high level of social stigma, their impairments tend to be minimized, and there is a disproportionate lack of services in our public health care system.

Mental and behavioural disorders are not minor injuries

The following sections demonstrate that mental and behavioural disorders are not minor injuries and can be easily differentiated from minor physical ailments and the distress that may accompany them.

i. Onset and prognosis

Psychosocial issues/symptoms/complaints such as upset and distress in most accident victims with minor musculoskeletal injuries are generally noted soon after the accident. In most individuals, good recovery may be observed within days and usually within the general 12-week time frame of the MIG. In contrast, impairments due to mental and behavioural conditions/disorders are more likely to have later onset (the exception being acute stress disorder, post-traumatic stress disorder, and specific phobias) and tend to be persistent. While there are effective treatments for these pervasive disorders, reduction of impairments and restoration of functioning often requires months to years. The longer recovery times are dependent upon complicating factors and individual response to treatment. Early access to psychological approaches are known to be effective in mitigating complicating factors and, since they are tailored to the individual patient’s needs, individual responses tend to be positive.

Given the nature of client responses, the subset of accident victims with impairments due to mental and behavioural disorders cannot be considered to have predominantly Minor Injuries or limited to the Minor Injury Guideline, as their onset is often delayed and prognosis is one of a more prolonged recovery. ***As such, the Minor Injury definition and Minor Injury Guideline should explicitly state that mental and behavioural disorders, documented by an appropriate health professional, are excluded from the MI definition and exempt from the MIG treatment Guideline, even when accompanied by minor musculoskeletal injuries.***



ii. Functional limitations

In addition to their persistence beyond the early post-MVA period, accident victims with psychological impairments due to mental and behavioural disorders can be differentiated from those with psychosocial issues/symptoms/complaints by the resultant functional limitations. While some accident victims with minor musculoskeletal injuries may have psychosocial issues/complaints, these would not be expected to limit their functioning in their personal, home, or work life. The distinction occurs where mental and behaviour disorders have developed to the degree that they result in impairment and limitation in functioning.

The higher level of disability due to mental and behavioural disorders is documented in *“Disability and Treatment of Specific Mental and Physical Disorders, Ormel, Petukhova, Von Korff, and Kessler, Global Perspectives on Mental – Physical Comorbidity in the WHO World Mental Health Surveys, edited by Michael R. Von Korff, et. al., Cambridge University Press, 2009”*.

The key message is that *“Disability ratings for mental disorders were generally higher than for physical disorders. Of the 100 possible pair-wise disorder-specific mental- physical comparisons (Table 18.4), mean ratings were higher for the mental disorder in 91 comparisons in developed and 91 in developing countries”*.

Therefore, a key component of appropriate mental health expert diagnosis of a psychological disorder involves evaluation of the impact on functioning. The mental and behavioural disorders require treatment in their own right to reduce impairment, restore function and reduce the likelihood of the disorder becoming a life- alerting chronic condition.

iii. Assessment by a health professional with expertise in diagnosis of mental and behavioural disorders

It is generally assumed that the screening for psychosocial issues and the need for supportive interventions can be provided by the health professional providing the assessment and treatment of the minor musculoskeletal injuries. The assessment section of the MIG states, *“It is understood that the review and documentation of functional status and psycho-social risk factors is within the scope of practice of the health practitioner and does not involve a formal psychological assessment”*. It should be noted that psychologists are not included in the list of practitioners who can complete the OCF-23, MIG treatment confirmation form (Chiropractor, Dentist, Nurse Practitioner, Occupational Therapist, Physician, Physiotherapist). This is consistent with the focus of the Minor Injury definition and Minor Injury Guideline on minor physical injuries. Psychologists do not perform the assessments and examinations required by the MIG provider, including conducting the physical examination and determining the physical diagnosis.

In contrast, the determination of impairments/disorders due to mental and behavioural disorders requires specialized expertise and authority to communicate the diagnosis (authority to perform this controlled act is limited to some members of the psychological and medical profession). Assessments of accident victims with mental and behavioural disorders should follow the processes outlined in the OPA Assessment and Treatment Guidelines. When appropriately conducted, the psychological diagnostic process can be compared to medical laboratory testing to guide treatment/rehabilitation. If the health professional providing the physical treatment for the minor musculoskeletal injury suspects a psychological impairment, the patient should be referred for screening and determination of the need for diagnostic



assessment/treatment to a regulated health professional with expertise in diagnosis and treatment of mental and behavioural disorders.

iv. Treatment by health professional with expertise in treatment of mental and behavioural disorders

It is assumed that the physical treatment provider can provide the supportive interventions required by accident victims with minor musculoskeletal injuries. The discretionary interventions during treatment section of the MIG Guideline states, *“If the insured person is displaying signs of distress or difficulties coping with the effects of his/her injury, the health practitioner may introduce pain management and coping skills education (a standardized approach is recommended)”*. In contrast, patients with mental and behavioural disorders present with a variety of highly specialized treatment and rehabilitation needs. Effective, efficient treatment/rehabilitation must incorporate both evidence-based guidelines, when appropriate, and individual factors. This requires health professionals with specialized expertise. Extensive specific education and training is required to provide the treatment/rehabilitation in a sound manner. In addition, it is essential to continuously evaluate and monitor the effect of treatment and modify as needed. Therefore only health professionals with this specialized expertise, such as psychologists, should provide treatment/rehabilitation of patients with impairments due to mental and behavioural disorders (in coordination with other treatment, if required, for the patient’s physical disorders).

v. Mental and behavioural disorders are not the “Clinically Associated Sequelae” of minor musculoskeletal Injuries

As discussed above, an accident victim with impairments due to a mental and behavioural disorder has a distinct disorder/condition, not a “clinically associated sequelae” of the minor musculoskeletal injury. The nature and severity of the mental and behavioural disorder is independent of the severity of the physical injury.

vi. Predominance of mental and behavioural disorders

In patients with minor musculoskeletal injuries as well as impairments due to mental and behavioural disorders, the mental and behavioural disorder usually comes to overshadow that of the physical injury and becomes the predominant cause of functional limitations in home, personal and work life and creates the greater health care needs. Therefore, in accident victims with psychological/mental and behavioural disorders, as well as minor musculoskeletal injuries, the psychological disorder is the *predominant* condition.

vii. Reduction in disputes

The OPA noted that section 1.2 in the Draft Statement of Priorities concludes with the statement that: ***“This will reduce disputes about benefits, and improve care provided to claimants”***.

We fully support efforts to reduce disputes. It is particularly difficult, however, for accident victims with mental disorders to endure disputes regarding their applications for services since they reinforce the stigma and dismissal of their needs as “real” and appropriately requiring treatment. In addition, while an insurer may obtain an Insurer Examination that may ultimately approve treatment, excessive insurer denials add needless costs to the system. In addition, this requires the accident victim, with a mental disorder, to undergo an Insurer Examination and



expose the most personal aspects of their life and recount what may be a highly traumatic event to a health professional who will not be their treatment provider. This process is often associated with significant further deterioration. We have observed too many patients with mental disorders harmed by baseless insurer denial of their applications for approval for funding of services. The denial and delay in access to services is particularly harmful given the lack of alternative services in the public health system as documented above.

It is particularly concerning to see that almost all applications for clinical assessment and treatment of mental disorders are denied by the insurer when the insurer has classified physical injuries as falling within the minor injury definition. We note that this occurs even when the patient is referred by the family physician that has identified a mental disorder and/or when there has been a comprehensive screening conducted by a psychologist documenting indicators of a mental disorder and need for psychological services. When the insurer denial is followed by an insurer examination, we note that these applications are ultimately approved in a very high proportion of the cases. Therefore, this needless denial is not only a burden for the patient that often results in worsening of their condition as treatment is delayed; it also adds costs and disputes to the system.

viii. Recommendations re: Development of the Minor Injury Treatment Protocol

- Clarify that mental disorders, documented by an appropriate health professional, (psychologists and physicians are the only regulated health professionals who are authorized to communicate a diagnosis of a mental disorder) are not within the minor injury definition. This would reduce harm to accident victims with mental disorders and costs associated by inappropriate denials while ensuring appropriate identification of individuals with these disorders;
- Improve education regarding the nature of mental disorders, with the aim of reducing discrimination and overcoming the continued narrow focus on severity of physical injury as a proxy for mental injury;
- Create and enforce standards for proper adjudication, including consideration of the relevant evidence-based guidelines when making decisions; and,
- Require insurer examiners to have appropriate education, training and experience. When obtaining insurer examinations, insurers should utilize health professional peers to comment on assessment and treatment. As one of two professions qualified to determine diagnosis of mental disorder, comment on reasonable and necessary treatment, comment on disability and catastrophic impairment due to these disorders; rely on psychologists to conduct these insurer examinations.