Ontario Rehab Alliance

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Houston Cheng
KPMG LLP
Bay Adelaide Centre
333 Bay Street Suite 4600
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Sent via email to: hhcheng@kpmg.ca

Dear Houston Cheng,

The Ontario Rehab Alliance is pleased to have been asked to respond to this survey.

Founded in 2009, the Ontario Rehab Alliance is a non-profit association representing 112 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 made a substantive submission to FSCO's Three Tear Review (attached here), responded to KPMG's Interim Transparency Report (attached here), 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.

We would very much like an opportunity to further discuss this response, and request a meeting at your earliest opportunity.

Questions #1 and 2

1. *In September 2010, the Government of Ontario introduced major reforms to the Ontario automobile insurance system with the intent to control insurance costs, increase choices available to consumers, and simplify processes in the automobile insurance system. How have you or your members been affected by the auto insurance reforms that were introduced in September 2010? Would it be possible to provide a qualitative assessment?*

2. *Have you analysed the impact of the 2010 auto insurance reforms on your members? If so, would you be prepared to discuss your findings? Would it be possible to provide the results of such quantification?*

Response:

The table below summarizes notable changes to funding following the 2010 reform:

Pre - 2010 Reform	Post – 2010 Reform
Med-Rehab Benefit: • $100,000 cap for all non-CAT injuries (representing 99% of victims) • $1,000,000 cap for all CAT injuries (representing 1% of all victims) Based on the above the weighted average Med-Rehab benefit cap is $109,000.	Med-Rehab Benefit: • $3,500 cap for all Minor Injuries (representing 75% of all victims according to published HCAI data) • $50,000 cap for all non-CAT injuries (representing 14% of all victims) • $1,000,000 for all CAT injuries (representing 1% of all victims) Based on the above the weighted average Med-Rehab benefit cap is $24,625. The reform has reduced the weighted average cap for the Med-Rehab benefit by 77.4%. Please note that the reduction in the Med-Rehab benefit is in fact greater because cost of assessments and examinations are deducted from the cap. In fact the reduction in this benefit is closer to 82%.
Attendant Care Benefit: • $72,000 cap for all non-CAT injuries (representing 99% of victims) • $1,000,000 cap for all CAT injuries (representing 1% of all victims) Based on the above the weighted average Med-Rehab benefit cap is $81,280.	Attendant Care Benefit: • No benefit for all Minor Injuries (representing 75% of all victims according to published HCAI data) • $36,000 cap for all non-CAT injuries (representing 19% of all victims) • $1,000,000 for all CAT injuries (representing 1% of all victims) Based on the above the weighted average Attendant Care benefit cap is now $18,640. The reform has reduced the weighted average cap for the Attendant Care benefit by 77.06%.
Housekeeping • $100/week for all victims.	Housekeeping • $100/week for CAT victims only This represents a 99% reduction in the benefit. Please note that we are not accounting for the optional nature of this benefit because an additional premium is paid for such an election.
Caregiver Benefit • $250/week (plus $50/week for additional dependents) for all victims.	Caregiver Benefit • $250/week (plus $50/week for additional dependents) for CAT victims only This represents a 99% reduction in the benefit. Please note that we are not accounting for the optional nature of this benefit because an additional premium is paid for such an election.

From the above analysis it is evident that reductions in AB-Non DI benefits ranged between 77% and 99%. We note that to date not all cost savings resulting from the reforms have been attained. This is due to the fact that claims with an injury date of pre-2010 are still being paid for within the higher limits. However, even with partial benefits, 2012 GISA data reflects a cost saving of 55.8% (i.e., in 2009 claims costs were $3,775M while in 2012 they were$1,676M).

While we understand that GISA data may not include overhead costs, in this instance it's a very useful tool to use to assess costs savings because it allows for an apples-to-apples comparison of direct AB costs.

Further, there have been additional savings which would not be included in the GISA data as they relate to overhead costs rather than benefits. For instance, the reform removed payment for Rebuttal reports and mandatory Insurer Examinations (IE's), which would account for significant savings to the insurance industry.

It is our view that the government's intended goal of providing consumer choice has failed miserably. According to FSCO's data the pick-up rate on optional coverage has only been 1.4%. We attribute this failure to lack of consumer education. We believe that if consumer were better educated on the inadequacy of their AB healthcare coverage in light of the high cost of healthcare-related goods and services not covered by AB or OHIP, many more would purchase the optional coverage.

Your question related to the quantification of the 2010 slashes on our membership is difficult to answer because the system is not transparent, but supposedly it's a portion of the reduction in AB costs as reflected by GISA. A more important question, however, relates to how to quantify the impact of the slashes on the claimants. How does one quantify the loss of life roles, loss of productivity, loss of meaningful activity and enjoyment of life? While these questions are the crux of the matter at hand, they are also well beyond our ability to answer. We did, however, attempt to tackle it by surveying our membership to gauge the recovery of their patients. Highlights are provided below:

- Only 17% of the seriously non-CAT injured victims attain their goals as compared with 57% prior to 2010.
- Only 50% of seriously non-CAT injured victims are able to return to ***half*** of their pre-accident roles and levels of function as compared to 85% prior to 2010.
- 26% of those who were treated in the MIG, receiving the initial $2,200 tranche, were denied access to the balance of $1,300 despite healthcare provider recommendations.

The above figures clearly show that the current non-CAT med-rehab funding is insufficient and while profitability of insurers is important so is the protection of injured victims, which is in fact the entire purpose of any insurance product. It is our feeling that the very essence of the auto-insurance product (being protection of victims) has been minimized to a level which begs the question of why do we even have the coverage in the first place? With the lowest healthcare coverage in Canada, our scheme in Ontario has turned into nothing much more than a road tax.

It is also noteworthy to mention that anecdotally speaking there has been a departure of experienced practitioners from the auto-insurance sector stemming from the $2,000 cap on assessments imposed by the 2010 reform. The departing assessors have for the most part been those with most experience and expertise who found it uneconomical to render services in this industry. As a result more assessments are now completed by inexperienced practitioners leading to an increase in disputes and cost to the system.

Questions: #3, 4 and 5

In November 2012, the Automobile Insurance Anti-Fraud Task Force issued its final report about costs of fraud and recommendations. Its recommendations involved multiple stakeholders such as the government, the Financial Services Commission of Ontario, insurers, health regulatory colleges, Law Society of Upper Canada, Workplace Safety and Insurance Board, Ontario Health Insurance Plan and Canada Revenue Agency. The 38 recommendations are classified under four headers:

- *Prevention;*
- *Detection;*

- *Investigation and Enforcement; and*
- *Regulatory Roles and Responsibilities.*

3. *Have the recommendations made by the Anti-Fraud Task Force in November 2012 and the actions that the Government and industry have taken since then affected you or your members? Would it be possible to provide a qualitative assessment?*

4. *Have you quantified the impact of these anti-fraud measures on your members? If so, would you be prepared to discuss your findings? Would it be possible to provide the results of such quantification?*

5. *Have you or your members implemented a program to combat auto insurance fraud? If so could you please provide a short description of the program?*

Response:

The ORA has from the start been a supporter of the Anti-Fraud Task Force and its work. We feel strongly that one dollar of fraud is too much and to that end we endorsed the recommendation to license healthcare providers. However, we have always warned against an overreaching approach to control fraud which would impact the ability of healthcare providers to deliver services or claimants from receiving them. Indeed, a number of the regulatory changes aimed at preventing fraud had this precise effect. It is not possible to precisely quantify the cost of such measures to the healthcare sector.

The major impact of the Anti-Fraud's Task Force's report was of course the requirement for all healthcare providers wishing to work in this sector to be licensed. The direct cost of obtaining and maintaining the newly required FSCO license is publicly available. In addition to that, however, there are indirect costs which are required by the regulation and relate to increased oversight and risk management. It is estimated that total direct and indirect cost represents a 5% to 10% reduction to an already slim profit margin.

The ORA has long promoted best business practices to its membership. In addition, the ORA has promoted licensing among its members providing seminars and, more recently, publishing a kit to assist members with implementing the licensing and oversight processes.

Questions: #6 - 13

In February 2014, Justice Douglas Cunningham released his final report and "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". The 28 recommendations are centered on seven principles with respect to dispute resolution system (i.e. timeliness, proportionality, accessibility, predictability, streamlining, costs and culture).

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

7. *Have you analysed 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?*

Response:

Effective rehabilitation is based on timely access to services which is precisely the reason for the establishment of Accident Benefits – i.e. prompt access to healthcare services rather than waiting years for a tort resolution. However, in the last few years we have seen an escalation in wait times of disputed treatment plans as many await access to dispute

resolution. While the mediation wait time has been addressed, many of the failed mediations have merely been exchanged for arbitration wait times. Denying and delaying treatment by disputing it works in favour of insurers because by the time a treatment plan is ruled upon the need might have come and gone. Examples include the need for safety equipment in an acute stage, or when conditions left untreated become chronic and untreatable. In the interest of providing treatment to claimants, the process of dispute resolution must be as speedy as possible.

Our association does not have the extensive resources required to undertake the quantification of denied and delayed treatment on claimants. Needless to say, there is a very significant human and economic cost associated with untreated injuries including pain, risk or actual re-injury, chronicity of conditions etc.

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

Response:

We are troubled by two points in the report: 1) Inability to access the court system in connection with Accident Benefits; 2) Imposing a threshold of $10,000 to access an in-person hearing. We feel that a $10,000 threshold would limit access to in-person hearings only to CAT cases where as many, non-CAT cases represent very severe injuries and needs, some of which eventually "graduate" to CAT determination.

9. *As part of the 2013 Ontario Budget, Government initiated the Auto Insurance Cost and Rate Reduction Strategy. The key elements of the Strategy pertain to anti-fraud measures, an average automobile insurance rate reduction target of 15%, licensing of health care providers in the automobile insurance system, transformation of the automobile insurance Dispute Resolution System and creation of a transparency and accountability mechanism in the form of an independent annual report by outside experts on the impact of auto insurance reforms introduced to date on both costs and premiums". What steps have you or your members already taken to reduce costs that would affect the automobile insurance product?*

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

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

12. *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?*

13. 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?

Response:

Since 1996 claimants and healthcare service providers have shouldered the consequences of cost savings in the system. For almost 20 years there has been a continuous erosion of the system to benefit the profitability of insurers. For instance, in 2003 healthcare provider fees were arbitrarily slashed by 30% with occasional increases equivalent to CPI. Despite such periodic adjustments, fees are still not close to the 2003 levels. In 2013 there was no adjustment to the fee schedule.

Our association has acknowledged the importance of achieving a reduction in premiums by combating fraud. To that end we supported the creation of a licensing regime which we knew would come at a further cost to our already beleaguered members.

More can be done to achieve costs savings by implementing the other recommendations of the Anti-Fraud Task Force such as the licensing of the tow truck industry.

In various papers published by the ORA we also recommended the following to reduce costs in the system:

- Reinstitution of like-for-like assessments
- Development of standards for IE assessors
- Develop rehabilitation adjudication guidelines for adjusters

- **Minimize Disputes**
  Reduce the number of arbitrary and unsubstantiated denials on applications for Assessment and Treatment (OCF-18s).

  Arbitrary and unsubstantiated denials take time – insurer adjuster time – as they give rise to repeated calls and requests for clarification from claimants, healthcare providers and plaintive lawyers. This adds to insurer administrative costs.

  The average reported decline rate of decline for Assessment and Treatment (comparing pre-Sept 1 2010 to April 2011 period) rocketed from 12% to 31% for Treatment, and from 12% to 29% for Assessment. That many of these denials were arbitrary or poorly founded is borne out by additional data that illustrates a corresponding increase of 58% and 16% respectively in the percentage of Assessment and Treatment OCF 18s approved by Independent Examinations , (those ordered by insurers), out of all OCF 18s submitted

- **Minimize the Need for Mediation & Arbitration**

  There has been a steady escalation in the number of disputes proceeding to mediation, and a corresponding increase in arbitrations. Dispute resolution is a costly process and the costs are borne by insurers, victims and regulators alike. The number of files requiring dispute resolution can be mitigated in the following ways:
  - Reinstate Mandatory Independent Exams (conducted appropriately) for disputed denials prior to proceeding to mediation
  - Institute pre- mediations discussions to clarify areas of dispute and create opportunities for early resolution
  - Involve the directly impacted parties (providers, insurers) in dispute resolution processes

We vigorously caution against any future erosion in Accident Benefits, the healthcare component of which is currently, the lowest in Canada on a weighted average. As things stand now, the available funds (to non-CAT and MIG) victims are completely inadequate for their rehabilitation especially given the lack of publicly funded rehab options such as those available in other provinces, to address such needs.

While we continue to consider a decrease in premiums as a desirable outcome we note that we do not agree that the relief should necessarily come by next year. There are a number of large initiatives (such as fighting fraud, changes to DRS etc.) on the way, the full benefits of which might take longer than 12 months to materialize. Consideration should be given to extend the deadline for the 15% premium reduction if it means that the full benefit of the current initiatives will materialize. To meet the reduction target however, pressure must be exerted on insurers to examine their own internal efficiencies in carrying out their business. Some insurers are operating with high efficiency and profitability due to superior leadership; others chronically rely on the government to bail them out by passing amendments to the Regulation. Because successive governments accommodated such pressure it has become modus operandi. For instance, why are insurers allowed to pay excessive hidden commissions to brokers only to then pass on the cost of such fees to their own clients (source: Globe and Mail article dated July 10th, 2014)? Why is it acceptable for insurers to spend equally (per claim) on denial of treatment (through IE's) as they actually spend on the treatment itself (Source: Ontario Health Claims Data Base, April 2014; http://www.ibc.ca/en/car_insurance/documents/facts/hcdb_standard_report_2013_h2.pdf)? This is clearly wasteful.

There is obviously much that insurers can do internally to produce costs savings. We believe that KPMG has a vital role to play in shining the spotlight on such opportunities rather than capitulating to endless insurer demands to reduce

benefits. Further, as the GISA data illustrates, premiums in Ontario could today be reduced by 15% and still allow insurers better than average profit margins.

Questions: #14 – 21

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

Response:
Please refer to page #5 in our 3-Year Review Submission attached. For nearly 20 years Ontario's auto insurance system has been undergoing continuous and frequent changes. Alarmingly, in the past short while such changes stared occurring suddenly and without any prior stakeholder consultation. Such regulatory amendments have strongly favoured the insurance industry which seems to be getting anything it wants thanks to its powerful lobby which seems to be backed by limitless resources.

Generally speaking, the uncertainty around the rate and nature of the regulatory amendments contribute to a very difficult operating environment. It is impossible to achieve any operational efficiencies and complete any business planning beyond the short term. Continuous change and instability in any business environment is considered a problem. All stakeholders in this sector suffer from the negative consequences of rapid and unpredictable change. Further, the rapid rate in issuing new regulatory amendments does not allow the government and FSCO to reflect on and analyze what truly works from prior reforms. Since injured claimants pay the highest personal price for inadequate benefit structure or protection from insurers, the government should not only avoid making frequent amendments without prior stakeholder consultation but also slow down the pace of change in order to properly evaluate the evolving impact of past changes.

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

Response:
We feel that the insurance industry is able to exert tremendous pressure on the government given its financial resources. Such pressure is exerted in the form of direct government lobbying and indirectly by investing in a PR campaign which changes public perception in a very self-interested manner. For instance the IBC's latest talking point is that 'Ontario's premiums are too high because too much money goes to for profit lawyers and clinics'. The insurance industry of course hopes that this will turn public and government attention from themselves to other stakeholders. The paradox is obviously that the insurance industry profits the most out of the premiums paid (no mention of that). The disproportionate financial might of the insurance industry drowns out all other stakeholder voices to the extent that the overwhelming number of changes made since 1996 have supported the insurance industry's profitability.

16. *Have you analysed 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?*

Response:
We are not able to quantify the uncertainty.

17. *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?*

Response:
A number of years ago the government called for more frequent mandatory reviews of the system by FSCO. The previous Five Year Review is now the Three Year Review, allowing greater frequency of policy changes in the auto insurance system. We believe that it is necessary to bring some stability to this sector and limit changes to once every five years. This will allow all stakeholders including insurers to design and gain efficiencies from new initiatives, systems, policies and procedures and it will better allow legal precedents to emerge. While these are but two examples, the benefits are obvious as it is widely accepted that insurers benefit from stable environments.

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

Response:
We believe that given the now minimal benefit structure available to victims (which is worsened by the lack of availability of government-funded healthcare), significant barriers to access those minimal benefits, and high percentages of premiums going toward insurer profitability, the government should consider reviewing the pros and cons of all and any auto insurance products, public or private that will provide the benefits insured drivers need and deserve.

While we understand that average premiums paid for auto insurance in Ontario are higher that other provinces there are a number of reasons to explain the difference:

i. In a recent Globe and Mail article headed "Why Ontario drivers pay the highest car insurance rates in the country" dated July 9th, John Bordigton, a spokesman for State Farm notes the following about Toronto, which population accounts for half of Ontario: "It's got the highest population density, the worst roads, and a high rate of theft. The costs reflect those risks". As a result premiums should be higher.

ii. From the 2010 overhaul of the SABS, to fraud-fighting measures, to DRS reform, and many more, Ontario's auto insurance system has experienced tremendous number of changes in the past four years. It is unfair to judge how affordable Ontario's auto insurance sector is until the benefits of these measures accrue and such costs savings can be fully accounted for.

19. *Have you or your members been affected by the following recent appeal decisions:*

    a. *Scarlett v. Belair?*
    b. *Pastore v. Aviva?*
    c. *Henry v. Gore Mutual?*

    If so, would you be able to provide a quantitative or qualitative assessment of how you or your members have been affected?

Response:
Please refer to our attached 3-Year Review Submission pages 19-21, discussing our position on the regulatory amendment to payment of the Attendant Care benefit resulting from the Henry Vs. Gore decision.

20. *Do you have any other comments?*

Response:
For additional comments please refer to attached documents.

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

Response:
No.

Yours truly,

Laurie Davis, Executive Director
Ontario Rehab Alliance