Ontario Rehab Alliance

51 Sophia Street
Peterborough ON
K9H 1C9

www.ontariorehaballiance.com
Toll Free: 866-475-2844
Toronto: 647-317-7244

# ORA Feedback on 'Fair Benefits Fairly Delivered: A Review of the Auto Insurance System in Ontario'

**Submitted to Yvon Baker, Parliamentary Assistant to the Minister of Finance, September 15, 2017**

The Ontario Rehab Alliance (ORA) welcomes this opportunity to share our perspective on Mr. Marshall's report.

Since its inception in 2009 the ORA has made its mark as a helpful and credible stakeholder. We are the only association in the auto insurance sector to focus solely on the needs and perspectives of licensed service providers and their clients, and we engage in proactive collaboration with other stakeholders whenever possible. We represent more than 134 provider companies employing thousands of Regulated Health Professionals and rehab support staff.

We have made constructive contributions to many policy development processes including the anti-fraud task force, implementation of service-provider licensing and the dispute resolution system review, to name just a few. We are pleased to be a part of FSCO's *Service Provider Industry Working Group* and *HCAI/Anti-Fraud Committee* and are committed to offering constructive contributions to the policy development process to improve the auto insurance med-rehab benefits system.

## Press Pause on Changes: Await Evidence

Wide-sweeping policy changes such as those suggested in the report should only be made on the basis of sound empirical data – data which is able to capture the impact of the past series of policy changes. Sadly, such data is not currently available. Further, the recommendations presented in the report are based on data that precedes the last wave of sweeping changes including: new CAT definition, reduction of CAT and non-CAT benefit cap, a new dispute resolution process and service provider licensing just to name a few. As Mr. Marshall indicated in his report, it may take a few years for major changes to yield results. Given that the above mentioned amendments were instituted only a year ago, we should wait for savings to be realized and empirical data to be analyzed prior to implementation of additional changes.

We strongly recommend that the HCAI data base be expanded to include a wider range of data regarding the costs and outcomes of the auto insurance system. Without a solid foundation of information, evidence-based policy decisions are not possible.

We support the overarching goals articulated in the report: timely access to benefits, appropriate treatment, less dispute and conflict, and more care. We do not concur, however, with the portrayal of the current system as one that is fundamentally broken and requiring dramatic changes as this is not congruent with our experience. The near-constant rate of changes made by government in the past decade have taken their toll – each change spawning some unforeseen consequences, and the impact of the changes going unmeasured. Additionally, each change has a structural cost associated with it to allow insurers and other stakeholders to adjust their business practices. Insurers pass these costs to premium payers which in turn increases

premiums. Such repetitive changes lead to incremental increases without waiting for savings to accrue before instituting a new change.

A period of respite from further change, until reliable data is available, is what is needed now. Further disruption might very well lead only to decreased system efficacy and eroded consumer confidence.

The report itself advises: "*carefully analyze what is lacking in the current model and incrementally correct it than to take a giant leap into a new system*"

We urge government to press pause on substantive change and await proper evidence and, in the meantime, make incremental changes to better ensure the right treatment at the right time (timely access) and to reduced disputes and conflict. Put measures in place to evaluate the impact of these changes, look at the evidence and then decide: what next?

## Recommendations

**Right Time: Timely Access**

1. Reduce the complexity of forms.
2. Use technology and innovation:
    a. Create an online portal where all documentation related to a claim can be uploaded for a client, allowing online completion and review by adjusters and treatment providers.
    b. Allow for electronic payments
3. Allow for immediate access to some portion of med-rehab benefits for initial treatment so there is no delay. Insurers should direct clients to rehab immediately. Waiting two weeks to initiate services upon hospital discharge is unreasonable given client safety concerns.
4. Insurers should direct clients to rehab immediately, with a check-and-balance mechanism in place to ensure this takes place
5. Eliminate the requirement to first exhaust extended health benefits.
6. Address these two significant delay points to eliminate pauses in treatment as the stop/start negatively impacts rehab progress, can cause conditions to regress and can lead secondary complications to arise such as anxiety, depression etc.:
    a) When further treatment post- MIG/CTI is required;
    b) When accident benefits are depleted in cases that may yet be deemed catastrophic.
7. Research and explore, possibly through a pilot project, the establishment of a "no IE, no dispute zone" for serious injuries up to a predetermined benefits threshold; this would be deemed a period during which there will be no dispute of treatment plans submitted by RHPs; as with the MIG, this would speed access to timely treatment and reduce disputes in cases of more serious injuries.

**Right Treatment/Right Treatment Plan**

The MIG/ CTI must be treated as guidelines and <u>not</u> be prescriptive; programs of care are expensive and hard to keep updated in tandem with ever evolving best practice.

51 Sophia Street
Peterborough ON
K9H 1C9
www.ontariorehaballiance.com
Toll Free: 866-475-2844
Toronto: 647-317-7244

We do not believe that insurance adjusters should be expected to develop expertise in medicine and act as "case managers" as the report suggests. Rather, they should be encouraged/mandated to adjust a claim based on advice from treating providers and ask questions about the proposed treatment.

**Right Use of Resources: Focus on Care**

1. Claimants' accident benefits should be used for care.
2. Re-insert Case Management into the basket of services available for non-CAT claimants; claimants with complex cases can then choose a Case Manager to assist them in obtaining the right care plan.
3. Accident benefits statements should be made available to all parties and be updated and shared more frequently.
4. Technology should be leveraged to improve transparency and communication of declining balances in treatment funds.
5. IEs should not be used to determine if an assessment is needed; a paper review is acceptable but an in-person assessment to determine if an in-person assessment is needed is a gross misuse of resources.
6. The public system is not able to support all the rehabilitation needed by those injured in auto accidents currently, let alone those who are catastrophically injured or whose accident benefits have been denied or exhausted.
7. Despite attempts at consumer education there is still little uptake of optional benefits, leaving those with serious injuries without sufficient coverage since the last round of cuts to the basic package; the Statutory Accident Benefits Schedule should ensure a minimum level of protection to properly protect Ontarians.

**Right People: Reduce Disputes & Conflict**

We support the need for qualified, neutral and consultative assessors but do not believe the proposed hospital based IEC model will provide for this, nor will it serve the goal of reducing disputes.

1. IEs must be required to meet strict timelines so as not to delay treatment.
2. IEs should not be binding nor pre-emptive; the priority should be on ensuring neutrality of the process, proper qualifications of the assessors and establishing quality standards in the IE process. Solutions for these concerns should be explored and objectively evaluated in consultation with healthcare providers, prior to implementation.

3. To avoid an adversarial approach to treatment, "snap shot" IEs should not prescribe treatment at the start, compromising the role and relationship between the client and their chosen treatment provider. The recommendations are not clear that a qualified multidisciplinary assessment (quite unlike those that may take place in the WSIB system) is envisioned.
4. IE providers should not be selected through an RFP process, but should be independently rostered to improve neutrality.

5. Communication between all parties should be required before denials are issued. IE assessors must consult with treating providers as part of the assessment to improve credibility.
6. To be regarded as experts, IE assessors should have relevant treatment experience to the client they are assessing. Hospital based professionals may have 'acute/immediately post-acute' experience and others may only have 'assessment experience' but not necessarily community rehab experience and this lack of this perspective creates more dispute and conflict.
7. Functional/contextual community assessments are key in formulating treatment recommendations, particularly for catastrophic determinations.
8. IEs should be like-to-like: eg. Speech Pathologists review Speech Pathologists' plans. IE assessors from other disciplines do not have the training to comment on the appropriateness of another discipline's specific treatment recommendations.
9. Insurers should provide claimants with a short list of names so that they may choose their IE assessor/examiner; client choice will improve buy-in and reduce conflict.
10. Limit how often IEs can be requested

**Right Payment**

We cannot support the report's recommendation to bring professional fees in line with those paid by WSIB. Professional fees in this sector have been eroded since the unilateral reduction a number of years ago and have not been increased since 2014. Lower WSIB rates have led to many providers no longer accepting WSIB work. On the other hand, our experience is that many WSIB case managers have to negotiate creative approaches to working with treatment providers to effectively increase the hourly rate so that work will be accepted.

More importantly, the comparison between WSIB and MVA professional rates is highly misleading. First, WSIB providers are, for the most part, large companies which can derive economies of scale in exchange for a high volume of work. This is obviously not the case in the auto insurance sector. Secondly, unlike WSIB, the auto insurance sector is infinitely more complicated and taxing in terms of required administration and regulatory burden. This leads to costs that are simply not present within the WSIB sector. For example, the licensing regime restricts payment to unlicensed service providers and equipment vendors. However, many products and services that are required by victims are sold by such unlicensed vendors. As a result, licensed providers not only have to arrange, but in many instances pay out of pocket, and then apply to insurers for reimbursement to deliver needed services to claimants. The administrative and financial costs involved in this process are very high; these costs are not present in the WSIB system.

**Right Regulator**

Healthcare may cost money, but it is not a financial service. The new regulator, the Financial Services Regulatory Authority (FSRA), should have health professionals knowledgeable about this sector on its Board and throughout that part of the organization who will regulate auto insurance and providers.

51 Sophia Street
Peterborough ON
K9H 1C9
www.ontariorehaballiance.com
Toll Free: 866-475-2844
Toronto: 647-317-7244

## Viewing Auto Insurance through a WSIB Lens

We commend the thoroughness of the report in looking at issues of access to benefits and care, and note that many of the report's recommendations understandably reflect Mr. Marshall's experience and knowledge of the WSIB system. However, looking at auto insurance healthcare through a WSIB lens is problematic. The mandates of the two systems are widely different: at WSIB the goal is to return to work; in the auto sector, it is return to life. The much narrower WSIB lens is consequently an imperfect tool.

In addition to the problem of the too-narrow lens, we raise the concern that the WSIB is not a model system. Many feel it does not work and it fails injured workers. What it may have gained in efficiency it seems to have lost in its current capacity to fairly assess and treat injured workers.

Several other aspects are worth noting here;

With respect to improved and timely access to care, we are concerned about changes that would lead to limiting client choice of healthcare provider and the impact this would have on the client's faith in the provider and, consequently, their investment in and commitment to the treatment program.

With respect to system efficacy and claims costs, we caution that discharge rates in systems such as WSIB, whereby providers are financially incented to discharge clients, should not be taken as an indicator that the injured are achieving their rehabilitation goals. The treatment deficit – whether in the WSIB or MVA sector – will not be addressed by OHIP funded services.

Programs of care most certainly have their place in the treatment of simple, frequently occurring minor injuries. We were pleased to see that the report recognized the limited application of programs of care for the treatment of serious and complex injuries.

## Apples to Oranges Comparisons

This report's analysis of the current system is predicated on the assertion that Ontario's auto accident benefit scheme is the most generous in Canada, and our claim costs, the highest. This assertion is based on a comparison of accident benefit payment caps to those in provinces with comparable systems. However, this is also an inadequate lens as it does not take into account the wide variance in the availability of publicly funded post-acute rehab in each jurisdiction and the consequent reliance on auto insurance benefits as a second or third payer. Further, the "richest system – highest claims" argument does not factor in the impact of the Minor Injury Guideline as its cap is the lowest in Canada.

## Conclusion

The med-rehab benefits provided by auto accident insurance play an important role in the healthcare safety net of Ontarians. Changes to these benefits or their delivery system should only be made in consultation with healthcare providers. The Ontario Rehab Alliance looks forward to the opportunity to continue our involvement in this conversation.