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

Care, Not Cash Default Consultation
Submitted by the Ontario Rehab Alliance

Via email to: AutoInsurance@Ontario.ca

September 16, 2019

Contact: Laurie Davis, Executive Director – lauriedavis@ontariorehaballiance.com

About the ORA**:** The ORA represents primarily small to medium sized healthcare businesses that collectively employ upwards of 4000 healthcare providers including Regulated Health Professionals from all disciplines, social workers, personal support and rehabilitation support workers. We are the primary providers of rehabilitation to Ontarians seriously injured in automobile accidents. Most of our members work throughout the healthcare system, giving us a wide-angle view. We are the only association focused primarily on the interests and issues of health providers in the auto sector.

Our member companies operate in home, community and clinic settings. As health professionals we have a strong duty of care to our clients, as business owners we have a responsibility to keep the business viable for ourselves, our staff, and the clients who depend on us.

On behalf of its members, the ORA advocates for motor vehicle accident victims, adequate insurance benefits, and fair treatment of those injured. We help members to navigate the claims system with timely information bulletins on new requirements and issues, and with resources to support daily operations.

4.4. Consultation Questions

Note: The ORA has focused its response of the consultation questions where we have expertise to contribute. We have responded to the others with 'no comment'.

Current State: Cash Settlements

1. What do you believe are the main reasons injured persons and insurers engage in cash settlements for auto insurance claims?

It would be most interesting to see data, if such exists, on this topic. Without access to data, we can only speculate based on our observations as healthcare providers. As such, we believe that the primary reason is frustration and disappointment with insurers' accident benefits (AB) claims management practices.

For many claimants, AB administration is experienced as "prove-you-are-not-a-malingerer-or-fraudster- and-keep-on-proving-that". The rate of treatment plan denials, dispute and the high incidence of insurer-initiated IMEs supports this narrative. Rather than feel supported by their insurer, claimants and their families too often feel as if they must fight for the treatment and support that they believed they were insured for. The fraught relationship with their insurer,

and the struggle to get treatment and other benefits, becomes an additional burden and energy drain, further compromising their recovery. Cash settlements free them from this unhelpful and unhappy dynamic.

Simply put, denials in this climate gives rise to disputes which leads to cash settlements.

2. If you are responding on behalf of industry, over the last ten years, what is the average: a) value of cash settlements by injury type? b) amount spent per settlement on non-medical care? (e.g., legal expenses, wage loss, independent examinations)

We are very interested in seeing the data collected through this consultation question.

Implementation Details: Care, not Cash Default

3. ***What could be done to facilitate earlier resolution of disputes regarding the delivery of care (including benefit entitlement, treatment decisions and assessments / insurer examinations)?***

There are many avenues to explore to avoid disputes and facilitate earlier resolution, such as:

- Reduce the number and frequency of treatment denials;
- Institute insurer accountability for fair and reasonable adjudication of claims; require more extensive and fact-based rationale than merely 'not reasonable and necessary' when overruling (by denial) a clinician's recommendation.

  Imagine what an MVA-style system would look in the OHIP system: GPs orders for lab work, diagnostic imaging or specialist referrals are subject to adjudication and routinely denied by back-office OHIP administrators. It would be clear to any and all that this is not the way to get people better.

- Institute an initial dispute-free 'zone' or phase which applies to all claims at outset, eliminating the need to determine or dispute whether MIG or non-MIG; credit trained and licensed health service providers with the capacity (reinforced by their Colleges' standards) to put the injured person's interests first.

- Improve the OCF-18 so that it provides for better information on which adjusters can base their decisions

Improvements to IME/3rd Party Assessments

Improvements to this aspect of the regime will go a long way to facilitate earlier resolution of disputes regarding the delivery of care. The ORA was pleased to be part of the working group consultation focused on this aspect of system improvement. We will not replicate all of that commentary here, but key recommendations include:

Institute minimum standards for IE assessors

Standardize the following:

- triggers for referral to IE
- referral questions
- what type of discipline to refer to for which questions
- the explanation of the assessment to the claimant
- the practice summary of the assessor
- the consent form
- the overall summary of the results (e.g. a 1-2 pager)
- NOT the clinical assessment report that supports it, although you could have some key headings that could be applicable for all disciplines

Establish a working task group to address the above with insurers, legal and healthcare providers represented.

Enhance the ability of adjusters to confidently provide treatment approval, when appropriate, without the need for a 3rd party-initiated assessment (e.g. training, more standardization) by:

- Standardization, as above (especially the triggers for referral and questions)
- Training for adjusters to include:
    - Roles and overlap of regulated and unregulated healthcare providers/clinicians
    - Sample injury and treatment scenarios with associated costs, (including home and vehicle modification, prosthetics and equipment needs) spending trajectory, for complex (serious and CAT) injuries
- Start double blinding the assessment referral or some alternate model that enhances the integrity of the system

Non- IME Related Suggestions

- More experienced adjusters for those outside of the MIG and especially for CAT
- Designated adjusters with high level of knowledge, Accident Benefits experience and skills who may act as internal resources for other adjusters for non-MIG claims
- Increased communication with treatment providers; adjusters should be required to discuss concerns with treating provider prior to triggering an IE.
- Reestablish case management for more complex cases (non-cat, non-MIG)
- Establish an affordable and accessible process to expedite treatment disputes, pre-LAT, such as using a panel of experts.

4. What types of extenuating circumstances for the exception to the Care, Not Cash default should be considered? Please include an explanation of the rationale and supporting evidence. With suggestions, please consider how to ensure clarity for consumers and insurers as to avoid unnecessary disputes.

The consultation paper proposes several exceptions to the Care, Not Cash default. We comment and elaborate on these, below.

Catastrophic Injuries

We support this exemption with these implementation recommendations:

> The trigger to open the door to settlement should be upon submission of an OCF-19. This will minimize disputes surrounding CAT designation and shorten the gap between exhaustion of non-CAT AB and CAT designation.
>
> Cash settlement not to be available until minimum 3 years post-accident to ensure sufficient time for injured persons to get traction and understanding of their rehabilitation needs and longer-term goal.
>
> When cash is provided for future care for children and adults without capacity and requiring substitute decision makers, this should be done through structured settlements to ensure funds will be available over their lifetime.

Costs to repair vehicles, income replacement benefits etc.

We support these being exempted.

Optional benefit to negotiate a cash settlement has been purchased

Many of the concerns we've articulated in our response to the consultation on the implementation of the $2 million CAT benefit level and the proposed buy-down option, apply here:

- Historically, few consumers buy-up accident benefits and this will play out in reverse if this option lowers price, resulting in the cheapest rather than the wisest policy.
- Most drivers do not consider it likely that they will be in an accident that leaves someone seriously, let alone catastrophically injured. They don't know they need it until they do.
- Insurance brokers and agents do not themselves understand the cost of serious and catastrophic injuries and are therefore not able to properly dissuade those deciding to "buy down"
- Implementation will need to mitigate all the above in order to ensure that Care, Not Cash does properly function as 'default'

Extenuating circumstances

We agree that relocation by an injured person out of the jurisdiction is a reasonable exclusion. This could be expanded to include situations where funds are required to assist relocating a family member to provide help to the injured person.

Other

Reimbursement for claimants when they have paid for reasonable and necessary treatment because the treatment required.

5. ***What would be the best approach and timing for the transition to the Care, Not Cash default to ensure consumers have sufficient time and opportunities to make informed choices (e.g., tie implementation to auto policy renewal dates, make it effective immediately for all claims, or make it effective for accidents that occur on or after a certain date)?***

Though the numbers of consumers who have a good understanding of the AB aspects of their policy is very small, the most consumer-centric approach is that of aligning the effective date with policy renewal dates.

6. ***In implementing Care, Not Cash, what are the concerns, challenges, and mitigation considerations that must be contemplated (e.g., insurers' claims management operations, health service providers' operations, consumer experience, etc.)? Please be as specific as possible based on your role in the insurance system***.

Unintended Consequences

Without proper safeguards and consumer/claimant protection mechanisms in place a 'Care Not Cash' system could well become one in which insurers are incented to deny so that the injured get neither care nor cash. The balance of power in this sector is currently skewed in favour of insurers who have much deeper pockets than claimants or healthcare providers. When an insurer denies a treatment plan now claimants may be able to retain lawyers that may sometimes appeal the denial through the LAT. If the proposed Care, Not Cash was implemented lawyers will not be able to represent victims. This means that injured victims, many of which may be dealing with post-accident cognitive and communication impairments, will have to take themselves to the LAT and face a technical process, making legal arguments with respect to a complicated regulation against actual lawyers acting on behalf of insurers. This is simply unfair and cruel.

Consumer Protection

We are very much in support of regime change that focuses on improving access to care and getting people better. However, we are concerned that implementation may compromise protection of claimants' interests if not done mindfully. Much depends on the extent to which implementation is accompanied by other changes that will positively impact the claims management experience of claimants. In the current culture of 'deny, delay & dispute' which seems to characterize too many insurers' claims handling practices, the injured rely on legal representation. Unless there are strong measures established to incent insurers to expedite claims, constrain denials, and uphold due process, claimants will be left in the lurch.

Lawyers will not be able to take on AB cases in a 'cashless' scenario. Claimants will not be able to retain lawyers, but insurers will. Mechanisms must be put in place to enable recourse to legal representation and/or establishment of impartial dispute process which does not favour the party with legal representation.

A funded mechanism should be established to enable claimants to secure independent legal representation to review proposed cash and/or structured settlements.

In those situations where claimants have received consecutive denials for treatments and are also unable to access cash settlements (the 'neither care nor cash' scenario), they should have access to independent legal representation funded through their auto insurance. This a vital requirement to ensure consumer protection and equity. Otherwise, only those claimants with private means to hire lawyers will be able to effectively challenge unfair practices on the part of their insurers.

Possible expansion of preferred provider relationships and the development of a policy option that would lower premiums if consumers agree to use preferred providers when purchasing their policies, have been floated as potential system changes. We believe such considerations could have profound impacts on consumer protection and treatment outcomes and therefore requires distinct consultation and thoughtful discussion.

Implementation Details: Optional Benefit (cash settlements)

7. ***What terms, conditions, limits, or other factors should the government consider in designing a cash settlement optional benefit?***

As discussed previously, we wonder about the viability of this proposal, as much as we appreciate the intent to increase the degree of consumer choice available. Though take-up of optional AB has always been extremely low, this is likely due to there being additional costs associated with them, in addition to their complexity. Ontario's auto insurance sector has had no experience with optional benefits which lead to lower costs, but our association would be concerned by the possibility of significant erosion of the Care, Not Cash default if the pricing is such that premiums are lowered by choosing this option.

Supporting Implementation: Consumer Education and Awareness

8. ***How should the insurance industry (insurers, agents, brokers) support consumer awareness and informed decision making with respect to a Care, Not Cash default and the cash settlement optional benefit?***

All stakeholders in this sector agree that aside from the cost of premiums Ontario consumers have a very low awareness of what, exactly, auto insurance is for and how it works. If this government's auto reforms result in improved consumer education and awareness that will be a tremendous accomplishment. We will reiterate here much of what we offered in our response to the $2 mil CAT consultation.

For the most part, the consumers we meet in the course of our work are already seriously or catastrophically injured. Rarely, did they have any understanding of the potential for such injuries before they occurred.

Insurers (brokers, adjusters) must be better informed so that they can then inform consumers. In our industry, it is the common experience that we, as consumers, have to educate - and almost persuade - our brokers and insurance agents in order to buy up the optional benefits we need. When we inquire of family and friends who we have encouraged to also buy-up they report similar experiences. Consequently, we believe that insurers will have to make a very significant effort to move the awareness dial.

Our association has developed resources to support broker and insurer education which we'd be happy to develop more fully and share more widely. We also provide some general information to the public and our clients:

Accident benefits and serious and catastrophic injuries are complex matters. In fairness, it may be asking too much of most insurers to do this well. The costs of healthcare are not well understood by most Canadians. OHIP is managed in such a way that most have no idea what their healthcare costs; only in the auto insurance sector are some of these costs visible. Without any context for understanding or comparing MVA healthcare and rehab costs insurers and consumers alike will be prone to seeing the real costs as inflated.

Addressing this issue in the MVA sector should come second to addressing it more widely and helping Ontarians better understand the costs of healthcare through a similar degree of transparency with the costs of OHIP, WSIB, etc.

9. What other opportunities exist to ensure consumer awareness / education?

The ORA believes that government, most likely FSRA as regulator, has a role to play in consumer awareness. Because auto insurance is mandatory, Ontarians should have easy access to the basic information they need without it being tied to product sales.

Additional Comments

10*. Please share any additional comments, suggestions or information to inform the proposed Care, Not Cash default.*

We urge caution in designing a system intended to mimic that of WSIB. There are very significant differences in the mandate and scope of the two regimes. These include, but are not limited, to:

- WSIB's focus is much narrower: return to work; the MVA system has the broader mandate of return-to-life
- Only working age adults are covered by WSIB
- There are no funding caps in the WSIB system
- Individuals do not purchase WSIB insurance, nor is there a choice of carrier