Ontario Society of Occupational Therapists

Response to Marshall Report
Fair Benefits, Fairly Delivered

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Ontario Society of Occupational Therapists

RESPONSE TO "FAIR BENEFITS FAIRLY DELIVERED"
September 15, 2017

Occupational Therapists in Ontario's Auto Insurance System

Occupational therapists (OTs) are regulated health professionals who work with people who, as a result of various health related issues including physical injury or illness and/or mental health issues, have barriers that impact their ability to manage their day to day activities at home, work, school or in their community. OTs assist individuals to rebuild capacity and ability, to participate in activities such as managing their own self-care, raising a family, working in or outside of the home, engaging in social activities, participating in their communities – occupations that give meaning and purpose to life. There are approximately 5200 occupational therapists in Ontario; 569 of the Ontario Society of Occupational Therapists' (OSOT) membership work in Ontario's auto insurance system.

- Auto insurers report approximately 50,000 to 60,000 claims for personal injury each year.
- Occupational therapists work, for the most part, with the 20% of claimants who have serious injuries including the ~1% that have catastrophic injuries, such as paraplegia, blindness, amputations and brain injuries.
- OTs work with people whose MVA related injuries *absolutely* impact their ability to manage their day to day living and employment skills.
- The insurance industry relies, almost exclusively, on occupational therapists to complete the Assessment of Attendant Care Needs (Form 1) to determine eligibility for this benefit; and then to assist the insured to overcome disability and return to normal life activities.

Occupational Therapists have played an integral role in the auto sector over the past 25 years with respect to assessing and treating injured claimants following car accidents. Some occupational therapists act in the capacity of Case Manager to assist claimants to navigate the auto insurance and community health care systems. Occupational therapy service providers in the auto insurance system are now regulated by the Financial Services Commission of Ontario. It should be noted that occupational therapists also have had a longstanding relationship in the

publicly-funded systems, working both in hospitals and within the home care sector, primary care and long-term care with clients across the lifespan.

A response from occupational therapists….

While OSOT did not have opportunity to consult with Mr. Marshall in the development of his report and recommendations, we are pleased to forward comments at this time.

The Society's response is based on the following principles and positions:

- **As client-centred professionals, occupational therapists have viewed Mr. Marshall's assessment of and recommendations for the auto insurance system with a focus on the claimant's experience of the auto insurance system and a commitment to ensure that all claimants be well served by their auto insurance coverage**.

- **The cost of auto insurance premiums needs to be managed but, current benefit levels cannot be reduced**. In fact, further health outcome studies are required to determine if the current levels are actually sufficient. Refer to Addendum re: details around the erosion of benefits over past 7 years.

- **The auto insurance system needs to be more consumer friendly, clear, transparent and more easily navigated so as to optimize claimant experience and timely access to necessary services and benefits**. Strategies to empower claimants to manage the system more independently are required. For example, simplify the OCF application process such that it is easily understood by the consumer, applications can be completed online and information can be accessed on the claimant's mobile phone

- **OTs advocate for greater funding for claimant treatment and restoration of function and less on assessments**. Mr. Marshall claims that $340 million is spent getting medical opinions.

- **The current IE system has inadequate controls to avoid referral bias, a perception of which has evolved over time.** OT identify a critical priority to reduce unnecessary assessment, maintain access to benefits and reduce perception of bias by structuring a system that can demonstrate objective, neutral assessments by assessors who have the skills and expertise to assess claimant status and need.

- **As rehabilitation professionals, occupational therapists see the value in providing claimants with access to quality treatment to return to function/work/school as**

opposed to cash settlements in most cases. Access to timely cash settlements for those with catastrophic injuries is appropriate when coupled with a life care plan and ideally with access to a Health Care Navigator who can assist the individual to plan for use and management of their settlement in relation to their needs.

- Ontario's auto insurance system has been structured to minimize impact and reliance on the publicly-funded health care system. **OSOT does not support increasing reliance/pressure on the public health system – it is already over-burdened.**

Overview of OSOT Recommendations

The Society has collected input from members working in the auto insurance system who have reviewed Mr. Marshall's report in detail. While we offer a response to several of Mr. Marshall's specific recommendations, the report has stimulated constructive review of issues raised and has resulted in alternative recommendations which are shared for consideration.

OSOT does not support any reduction to the current level of benefit coverage and is generally unsupportive of the recommendation to develop a suite of additional programs of care. We assert that if the goal is cost containment and savings, that there is considerable opportunity to achieve this by reducing the adversarial nature of the SABS. The Society proposes the following strategies to address this goal:

1. **Establish a structure for independent examinations that can assure neutral assessments that serve both insurer and claimant initiated referrals. Assuring neutrality and consistency of practice standard across evaluation sites is critical to reducing dueling of assessments.** To this end, occupational therapists propose:
    - Assessments be conducted at a FSRA-rostered centre, which meets standards set for assessment centres whether they are hosted in a hospital or the private sector
    - Assessment referrals are forwarded from FSRA and assigned according to postal code proximity to the claimant
    - Assessment referral sources must be blinded to minimize risk of bias
    - IECs must ensure like-professional, in-person assessments
    - Assessor credentials and expertise must meet specific standards set to assure competence and knowledge of the insurance system
    - Examination standards should require consultation with the treating provider as a compulsory component of a neutral assessment around medical, rehabilitation and attendant care benefits

- Assessments cannot be considered final and resolute; the claimant should be provided a second opinion and/or an opportunity to dispute

2. **Support "care not cash" approach for non-CAT claimants**
    - When cash is not an option claimants may be more motivated to recover
    - Support current MIG/CTI which addresses approximately 80% of injuries
    - Should additional treatment be required after the MIG, the adjuster may approve an OCF 18 or refer for an independent examination (IEC)
    - Claimant should have opportunity for a second opinion should they not agree with the recommendations of the IEC, however thereafter the claimant must choose one of those opinions
    - If the claimant should choose to dispute the recommendations of an IEC, the adjuster may opt to offer an alternative option – a prescribed Health Spending Account. This would be an amount of funding which could be self-managed by the claimant but restricted to solely accessing treatment from a FSCO-licensed provider. Such an approach allows increased choice and self-direction for the claimant, may lead to resolution of the health issue and may result in avoidance of costly dispute processes. This proposal is more fully explored later in this document.
    - A rostered health care navigator (optional) may be assigned to a claimant who has been given a Health Spending Account to support decision-making regarding treatment options.
    - Claimants with serious injuries would be offered similar options, although it is expected that adjusters would have approved a number of OCF-18s prior to engaging a Health Spending Account.
    - For those with serious injuries awaiting catastrophic designations, engage a Transitional Treatment Fund to bridge the gap until CAT designation is determined.

3. **Simplify CAT definitions and shorten timeframe for CAT determinations**.
    - Assure swift settlement for CAT claimants along with a life care plan to determine how funds are spent and the option of a health care navigator to guide the claimant in accessing treatment and supports as required.

Detailed Review of "Fair Benefits, Fairly Delivered" Recommendations

OSOT has reviewed Mr. Marshall's report and provides specific detailed responses to several of his recommendations below.

Lifetime Management

Marshall Recommendation 3. The regulator should undertake serious discussions with the Ministry of Health and Long-Term Care to develop a service for lifetime management of care for seriously injured accident victims. Eventually, as the province develops this expertise, the expertise and even services could expand to address other injuries outside of the auto insurance system. This would allow for continuing improvements in care to develop and recommendations for preventative measures to be generated while ensuring that patients are being treated by a reliable and sustainable system.

OSOT does not support lifetime management of those seriously injured in car accidents to be undertaken by the Ministry of Health and Long-Term Care.

Occupational Therapists working in this province have experienced firsthand the dearth of services available to those Ontarians who have chronic illnesses or have been injured outside the auto insurance sector. In our opinion, the Government has a very long way to go in providing "lifetime management of care" to those with developmental delays, severe autism, brain injury, mental health issues, Alzheimer's, cerebral palsy, and many other disabilities before assuming the "lifetime management of care" of those injured in car accidents who have access to private insurance coverage.

The Marshall report explains, *"Eventually, as the province develops this expertise…",* however, this statement suggests that, during the interim period, it leaves injured accident victims without the long term care they need. The Marshall report (p. 9) states, *"Nor does the solution, purely from a cost point of view, lie in changing from a private sector delivery to a public sector delivery system."* While Mr. Marshall was referring to the delivery of the insurance product in this statement, OSOT positions that the same philosophy applies to providing long term care in a private sector delivery model.

Catastrophic Designation

Marshall Recommendations 4 & 5. There should be a minimum of disputes and delays in accessing single lump-sum awards for those who are catastrophically injured. Such awards, should be efficiently and quickly determined by an independent examination centre and based on objective measures, such as the American Medical Association guide, supplemented, where appropriate, by specialized and well-established guidelines.

Insurers should make sure that seriously injured persons are given top priority and do not need to hire lawyers or other professionals to get their entitlement.

Occupational Therapists often assist catastrophically injured claimants during their transition from hospital to home, and OTs are typically the first to assess and treat catastrophically injured persons in the community. Occupational Therapists have witnessed firsthand how a claimant's funds can quickly become depleted while awaiting catastrophic designation, and/or afterwards.

OSOT proposes an ideal system in which CAT assessments are assigned within a 2-week period and, provided the team has all the information required to make the decision, the determination summary report occurs no later than 2 weeks later.

OSOT positions that, by cashing out catastrophically injured claimants ("lump sum settlement") swiftly and giving claimants choice of self-directed, self-managed long term care, this may prove to be the cost-savings insurers are seeking while, at the same time, giving claimants autonomy, and the health outcomes they can create for themselves.

OSOT supports cash settlements for catastrophic claimants, ideally, without the need for legal representation, however if this is not possible (defer to a legal opinion on this issue), OSOT recommends exploration of the development of a standard no-fault legal fee that is paid by the insurance company to the lawyer and does not come out of the insured's limited CAT funds.

Introduce Life Care Plans and Health Care Navigator to support management of lump-sum settlements

Mr. Marshall states: *"Injured persons who receive a lump-sum settlement during a period of crisis in their lives should not be forced to figure out how to make the settlement work for their needs, not only now, but also in the future…lump sum settlements could very well run out during the lifetime of the injured person."*

While OSOT supports a swift settlement for the catastrophic claimant, we also recognize that it is important to protect the injured claimant's funds given that their no-fault benefits are finite and may be clearly insufficient for lifetime care, and/or their tort settlement may be several

years away, if they have one. OSOT recognizes that it becomes a delicate balance of providing sufficient treatment/care while not depleting, possibly, their only source of future funding.

OSOT positions that the insurer should obtain a Life Care Plan[1] for any claimant receiving a lump sum settlement. A life care plan defines how health care dollars would be used for future health expenses. These monies should be deposited in a Health Care Spending account. Further, we suggest that a claimant be randomly assigned a certified Health Care Navigator who would help guide the individual in using these funds for appropriate health care expenses.

A certified Health Care Navigator would be a regulated health professional who is registered as a Navigator through the Financial Services Regulatory Authority (FSRA) after meeting defined qualification criteria such as completing a post-graduate certification program, and required to carry out a standardized approach using standardized forms. The Navigator services would be funded by the insurer but, by virtue of random assignment through FSRA, would have no relationship with any insurance company or law firm.

To recap, OSOT recommends:

1. The insurer should obtain a Life Care Plan for any claimant receiving a lump sum settlement in order to define how this benefit should be spent.
2. The lump sum settlement should be placed into a health care spending account.
3. The claimant is assigned an **independent and rostered Health Care Navigator** whose services are funded by the insurer, assigned by roster by FSRA and has no relationship with any insurance company or law firm and who can:
    - Access and review the injured person's medical and rehabilitation record and life care plan; and
    - Assist with budgeting the claimant's health expense account as per the Life Care Plan (or a modified life care plan over time).

OSOT suggests that the same approach should be taken with a claimant's future health expenses that arise from a tort claim. In this way, funds earmarked for "future health care" or "attendant care" under Future Expenses and Losses damages are specifically used in that way, thus preventing the claimant from going to the public system when funds have been used for expenses other than those for which they were originally intended.

[1] The **Life Care Plans are frequently used in the USA to determine the health care costs of persons with long term health issues as a result of disease or injury. A Life Care Plan** is a dynamic document based upon published standards of practice, comprehensive assessment, data analysis and research, which provides an organized, concise **plan** for current and future needs with associated cost for individuals who have experienced catastrophic injury or have chronic health care needs. http://ripplelifecareplanning.com/wp-content/uploads/2014/11/IALCPStandardsofPractice-2009edition.pdf

Transitional Funding

As noted in the Marshall report: *"…the [seriously injured] claimant may wait a year or more to receive confirmation" regarding CAT designation, a period which is "stressful" for the claimant and his family while "using up their lower tier of accident benefits and accessing the regular OHIP and social support systems." In the meantime, they are forced to hire a lawyer and ultimately receive "significantly less than the $1 million benefit" as a result of medical examination and legal fees"*

Occupational therapists are typically involved in the treatment of this group of individuals who exhaust their medical and rehabilitation benefits as they await catastrophic designation. OSOT proposes that policy structure allow for a **"transitional treatment fund**" which would continue to fund treatment for these claimants until such time as the catastrophic designation assessment has been completed or disputed.

Programs of Care and Introduction to a Health Spending Account

Marshall Recommendations #6 & #7. The regulator should move as quickly as possible to create programs of care for the most common types of automobile injuries. The programs should be based on the evidence-based findings of the Common Traffic Injury Guidelines.

The regulator should be provided with a sufficient budget to monitor and continuously improve the outcomes of existing programs of care and partner with the government on research into the development of new programs of care as the need arises – for example for neurological injuries, injuries from concussions, spinal cord injuries, chronic pain and post-traumatic stress disorder. Consideration should be given to leveraging existing programs of care that have been developed by other jurisdictions.

OSOT concurs with Mr. Marshall that programs of care should exist for *"the most common and high-volume"* injuries; however, OSOT submits that this has already been achieved through the MIG and/or CTI and does not support the development of additional programs of care. OSOT also concurs that health outcomes for programs of care should be tracked with particular attention to measures relating to function.

In lieu of additional programs of care to control costs, OSOT recommends exploration and piloting of a model that allows insurers to provide Health Spending Accounts to be self-managed by claimants to direct ongoing treatment.

OSOT has been directly involved in the development of the first two programs of care in auto insurance: the Pre-Approved Framework (PAF) in 2003 and the current Minor Injury Guideline (MIG) in 2010. There were 7 years in between the PAF and the MIG. In 2012, a group of researchers and specialists began researching and developing the Common Traffic Impairment

(CTI) program of care at a cost of $2.8 million[2], however, 5 years later, the CTI has still not been operationalized.

OSOT has concerns regarding the development of additional Programs of Care (POC) for the following reasons;

1) As evidenced over the past 14 years, it is difficult to maintain up-to-date, relevant programs of care as scientific evidence is continually evolving, and is sometimes controversial and/or flip-flops. The challenge and cost of monitoring evolving evidence and modifying POCs to maintain currency is magnified if the number of programs of care is increased.

2) The development costs have proven to be significant both in terms of real costs of consultants and researchers and the unpaid costs of professional association participation, review engagement, etc.

3) Within any Program of Care, there must be room for clinical judgement, best practices and individualized treatment approaches to allow for patient uniqueness, e.g. age, recovery time, cultural differences and beliefs, etc. Notwithstanding a program of care can provide clinical guidance, a one size fits all approach does not always work.

This position notwithstanding, *if* new POCs were to be developed, the regulated professional health care associations must be involved in development and valuation of POCs given their understanding of how treatment is delivered in Ontario, its frequency, costs, health outcomes etc.

Rather than multiple POCs to contain costs of treatment, OSOT proposes an alternative approach for consideration. For claimants that have completed the MIG/CTI or a Treatment Plan (non MIG claimants) and still require treatment, it is expected that the insurer would refer to an IEC. If the IEC treatment recommendations fail, a subsequent option could be offered: a **health care spending account(HCSA), dispensed in a measured way by the insurer.** We believe this option could;

- effectively save insurers (and ultimately consumers) millions of dollars in the development and maintenance of POCs;
- allow the insured to self-direct and self-manage his/her care with a regulated health care practitioner(s);
- ultimately improve health outcomes and consumer satisfaction, and

[2] https://www.thespec.com/opinion-story/7368266-opinion-ontario-captive-to-industry-demands-on-insurance-rates/

- streamline insurance administrative demands.

If the claimant requires guidance to manage their Health Care Spending Account, the insurer would permit a specific number of hours with a randomly chosen, certified **Health Care Navigator**. This type of self-directed program places the onus on the insured, with the help of their Health Care Navigator, family physician and treatment team, to spend their health care dollars wisely.

The NHS in the United Kingdom has developed a Choice Framework. One of its tenants is: *"All GPs/referrers discuss the different treatment options available to patients, include them in shared decision making, and offer choice to patients."* Studies undertaken to analyze "patient choice" appear to underscore the importance of patient choice of service provider as it relates to health outcome[3].

The Ontario government itself appears to be shifting the responsibility of long term care from the MOHLTC over to the individual and their family by giving funds directly to persons with disabilities in Ontario, such as Passport Funding[4] and Self-Managed Direct Attendant Care Funding.[5] On March 27, 2017, the government announced their direct funding model for families with a child with autism.[6] The recent Dementia Strategy suggests that providing funding to self-direct care may prove to be one direction the government is considering.[7] Even Mr. Marshall's report has an entire section dedicated to "consumer choice" and opines: *"Consumer choice is a powerful force that is going to change the nature of auto insurance in the not too distant future."* (p. 68)

OSOT believes that by introducing patient choice through a Health Care Spending Account (HCSA), it will take the onus off insurance companies and adjusters to make health care decisions, and ultimately may lead to better health outcomes, more satisfied customers, fewer disputes, fewer independent assessments, and significant savings for insurers while, long term, reducing insurance rates for drivers in Ontario. In other words, there would be no need for additional Programs of Care in this model.

[3] "Choice" in Health Care: What Do People Really Want?, Jeanne M. Lambrew, Ph.D, The Commonwealth Fund, Sep, 2005, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2005/sep/choice--in-health-care--what-do-people-really-want/lambrew_853_choice_ib-pdf.pdf
[4] https://www.dsontario.ca/direct-funding
[5] http://www.dfontario.ca/
[6] https://www.thestar.com/news/queenspark/2017/03/27/minister-favours-direct-funding-as-option-for-autism-services.html
[7] Dementia Strategy: "There may be opportunities to better support care partners and people with dementia by allowing them to decide what services they need or want and to determine how money is spent on these services."

Pilot introduction of Health Care Spending Accounts: OSOT strongly positions that, similar to the MOF's Basic Income Pilot roll-out in 2017 in Ontario, the MOF could conduct a 'proof of concept' pilot project in a defined geographical area(s) whereby claimants are given the option of a self-directed health care spending account along with a health care navigator, and then evaluate the health, functional (e.g. return to function) and financial outcomes.

Independent Examination Centres (IEC)

Marshall Recommendation #8. The government should empower the regulator with the authority and direction to establish a roster of independent examination centres (IEC) which should be hospital-based and must be able to provide a multidisciplinary team to provide appropriate diagnoses of injured patients and recommended treatment plans. Insurers must follow, without dispute, the recommendations of the IEC for future treatment within the financial limits of the insurance policy as provided by law. The dispute resolution process must respect the evaluation of the IEC without resorting to competing opinions from either party to a dispute.

OSOT supports the creation of a new independent examination system which is FSRA-rostered in order to minimize bias and consumer perception of bias. The Society can support locating IECs in either the private sector or in hospitals (or in both) as location is not deemed as a critical a variable as structures that will eliminate the potential for bias and promote standards for the skills, competence and expertise of assessors.

OSOT does not agree that the IEC determination be final and resolute; there must be room for second opinions as no one examiner is infallible. The claimant should be allowed the opportunity to attend a second IEC, randomly chosen in his/her geographical area, if he/she disagrees with the first opinion. The claimant would then have the choice between the two opinions

Assuring Neutrality/Eliminating Potential for Bias

OSOT positions that in order to best assure neutrality and objectivity, any new assessment system which replaces the current system of dueling assessments must:

- provide independent assessments for both insurer and claimant requested assessments
- register and roster Independent Evaluation Centres (IEC) through the new regulator, i.e. FSRA, which would eliminate the Request for Proposal (RFP) process currently in place with insurance companies
- assign referrals to an IEC by the regulator with the referral source blinded so that assessments are not subject to potential bias. To this end, reference to a law firm on the file must be redacted to ensure impartiality
- send claimants to the IEC closest to their postal code
- provide in-person assessments rather than paper/file reviews
- assure peer to peer assessments
- not be able to refer claimants to treatment within their organization.

Training and Qualifications of Examiners

OSOT asserts that an IEC, regardless of where it is located, must assure that examiners meet training and qualification standards and would be randomly selected within each IEC as assessments are required. The Society recommends;

- Establishment of criteria for specific professionals (e.g. 5 years clinical experience in the area in which they are assessing) that are required for specific assessments
- Standardized reporting style/format
- CAT assessors should be certified as per the new tests that have been introduced into the new CAT definitions as of June 1, 2016

Further, the Society identifies the following strategies to assure efficiency and effectiveness of IEC examinations;

- As a mandatory component of the IEC examination process, the IEC examiner must consult with the treating provider with respect to a medical, rehabilitation or attendant care benefit before the examination is considered complete.
- Centralizing electronic records such that treating personnel and IE examiners have the same access to the same materials

Hospital-based IECs

OSOT does not object to the recommendation that IECs be placed in hospitals *if* the following assertions can be supported;

- IECs in hospitals will not be a drain on publicly funded resources – IECs would develop as privatized arms of a facility, employing/contracting expert assessors separate to publicly funded hospital resources (examples already exist in the GTA)
- Credentials, education, training and expertise of assessors meet identified standards, e.g. years experience in sector, understanding of the SABS benefits
- IECs cannot refer claimants for treatment to their treatment facilities as this would be seen as a conflict of interest
- No one or two hospitals would have a monopoly with respect to IECs across the province
- Issues relating to the impact on private business owners (current IE operators) would need to be considered and addressed.

OSOT is not in the position to assess how feasible it is to create/mandate hospital-based IECs. This would require inter-ministerial discussions and consideration of LHIN priorities across the province. It would be critical to assure that any movement in this direction would not negatively impact growth, development, or attention to publicly- funded hospital services. If the model would promote a means through which publicly-mandated insurance funds are funneled to the public health system, this may be a positive strategy to support the public health system. This assessment remains outside the scope of OSOT's review.

When would an IEC be required?

OSOT assumes that IECs would assess a claimant when there is a dispute around:

- When the MIG/CTI has been insufficient to meet the claimant's needs and the claimant's treatment provider has submitted a treatment plan for more or different treatment;
- For those claimants who are not MIG (~20%): when the adjuster questions a treatment plan;
- To make a catastrophic determination;
- To determine if the claimant is ready to return to work and no longer qualifies for Income Replacement Benefit;
- When a dispute arises with respect to other medical, rehabilitation or attendant care benefits the claimant or his treatment team believe he/she requires.

Importance of Second Opinions

Marshall Recommendation #17 and 24. In relation to medical condition and treatment, the opinion of the independent examination centre should be taken as definitive by arbitrators. If, in exceptional circumstances, the arbitrator has reason to be concerned about the independent examination centre opinion under consideration, the arbitrator can ask for a second opinion from a second independent examination centre from the regulator's roster. Competing examination opinions from experts hired by either the claimant or the insurer should not be permitted.

The independent examination centre's opinion as to the claimant's medical diagnosis and future care needs, should be given a zone of deference by the courts in tort cases. This means that the opinion of the independent examination centre should be taken as definitive unless there is compelling reason to doubt it.

OSOT does not support this recommendation and urges consideration of the option to allow the claimant a second opinion through a second, FSRA assigned IEC. Further to the second opinion, the claimant is obliged to accept one outcome.

OSOT positions that no one examiner is infallible. Further, the IEC assessment is a "snap-shot" in time and may not be relevant weeks or months later. The claimant should be allowed the opportunity to attend a second IEC, randomly chosen in his/her geographical area, if he/she disagrees with the first opinion.

Occupational therapists note that for 100% of non-CAT cases there is no incentive to remain "disabled" because:

- there is no cash settlement for these claims AND
- if the SABS file CANNOT be used to boost the tort claim, thus preventing "gamesmanship" on the no-fault side.

In such cases, if the claimant continues to suffer then we can assume he/she continues to suffer from symptoms not recognized by the initial IEC assessment team. Furthermore, there are often alternative treatment approaches to the same condition which physicians, of variable training and experience, may recommend.

We continue to support the ability for the claimant to dispute a claim at the LAT as a last resort.

Qualilty Control

Marshall Recommendation #9. The regulator should conduct regular quality control studies of the outcomes of future care recommended by IECs to monitor the quality of such recommendations and ensure their effectiveness. As part of this process the regulator should consider instituting a system of professional peer review of roster assessors to ensure quality is maintained.

OSOT positions that quality control studies should be an integral part of IEC operations and should address:

- claimant satisfaction surveys immediately following the IEC assessment;
- health outcome surveys once the claimant has received the IEC-recommended treatment to determine how effective the prescribed treatment was;
- anonymous peer review of assessors' reports with recommendations for improvement;
- tracking of timeliness of obtaining IEC appointments and report delivery
- standardized consent forms for IECs.

Professional Fees

Marshall Recommendation #10. The regulator should undertake a complete overhaul of the pricing schedules for treatment by providers and evaluators to bring them more in line with prices being paid by other similar bodies, such as workers' compensation boards, and to emphasize outcomes rather than the number of treatments.

OSOT expresses concern a focus on health provider fees as a continuing source of cost control Further, the Society would caution comparison of unlike systems. While occupational therapists are not adverse to emphasis on outcome rather than the number of treatments, compensation needs to provide fairly for delivery of services to achieve outcomes.

OSOT positions that our new regulator (FSRA) must meet its fudiciary responsibility by respecting our usual and customary rates as determined by our professional association and must not determine fees unilaterally; fees must be negotiated with the respective professional association

In 2003, occupational therapy rates, along with the rates of all other allied health professions working in the auto sector, were arbitrarily reduced by 30-50%. OT rates have made a gradual return to 2003 rates over the past 14 years with eight (8) cost of living raises over this period of

time. A 2017 rate has not been communicated. These rates do not reflect specialized training or experience.

The Marshall report references Ontario WSIB rates and consideration of compensation in other systems. We note that the fees paid to OTs in the WSIB system are far below the usual and customary fee as established by our professional association and in the private sector. Some of our members have negotiated higher fees when working with WSIB clients or simply choose not to work with WSIB clients. Furthermore, it is difficult to compare systems which have different end goals and mandates, i.e. WSIB compels employers to accept employees back to work with modifications whereas MVA insurers do not have this power; the SABS requires the person to return to all his/her life roles versus solely his/her employment.

In Ontario, the current published rate for a WSIB OT in-home visit is $127.49. Typically, visits in a client's home run 1.5 to 2.5 hours plus travel time (assume travel 0.5 hr each way) as little can be accomplished in just one hour. Consequently, the OT's time to conduct an in-home/community visit is 2.5 to 3.5 hours, paid at $127.49 per visit = $36.45 to $50.99/hour. This represents less than 40% of occupational therapy usual and customary contract rates

The goal of rehabilitation as it relates to the SABS is returning the injured individual to pre-accident function, or close to it. Occupational therapists are well positioned to undertake this role by minimizing disability and by empowering claimants to resume their pre-accident roles. However, OSOT emphasizes that work performed with the claimant must be in-vivo—in the home, workplace, school, or community. This *is* the work of occupational therapists! There are no short-cuts, so occupational therapists must be fairly compensated for their time, both to travel to the claimant and while delivering care in the community*. Fair benefits, fairly delivered and fairly compensated.*

The same tenant holds true for occupational therapy and other expert opinions. The $2000 assessment fee cap was instituted in 2003 and has not been updated since in relation to the cost of living adjustment (COLA). Since that time, the auto sector has lost many of its expert assessors and the sector has suffered financially as a result. Paying health care professionals fairly saves the system money

To provide some perspective around billing rates, consider that the January 2017 *Physician's Guide to Uninsured Services-A guide for Ontario Physicians—Billing for Uninsured Services*[8], which recommends a billing rate of $376.65/hour for Life and Health Insurance Report and Assessments for a full narrative report. In comparison, allied health professionals, most of

[8] http://web.ncf.ca/ex864/schedule/docs/ThirdPartyGuide.pdf

whom have Masters Degrees or the equivalent, are being paid approximately 1/3 this rate or approximately $100 to 135/hour. To suggest a lower remuneration than this depreciates the value of our professional contribution.

Care not Cash

Marshall Recommendation #11. There should be no cash settlements in the accident benefits portion of the Ontario auto insurance system for those benefits specified in the legislation as being for medical and rehabilitation care. Where the legislation provides for cash payments, for example for lost wages and lump-sum payments for catastrophically injured persons, these would, of course, continue to be paid.

OSOT supports the recommendation for no cash settlements for non-catastrophic claimants while at the same time asserting the need to ensure that the original intent of no-fault insurance is met—providing medical and rehabilitative care to injured accident victims. A similar strategy appears to be supported by Dr. Cassidy's study in Saskatchewan where treatment was provided rather than cash (p. 56).

We believe that, following the MIG/CTI and once the IEC recommendations have been exhausted that by giving claimants a treatment-only fund (Health Care Spending Account) rather than cash that this strategy will actually reduce claims costs and over-utilization in the system.

Insurers' and the Regulator's Responsibilities

Marshall Recommendation #14. The regulator should monitor, on a continuous basis, the length of time insurance companies are taking to provide benefits to claimants and determine if undue delays are causing financial harm to accident victims.

OSOT concurs.

Insurer Internal Appeal Processes

Marshall Recommendations #15 and 16. Insurers should be required to establish an internal appeal process to provide an early resolution to claims and reduce the number that have to proceed to the external dispute resolution system. The regulator should monitor the effectiveness of the internal appeal process and be empowered to order corrective action if a particular insurer is generating an unusual number of claims to the dispute resolution process.

The gatekeeper function at the Licence Appeal Tribunal should insist that a claim has gone through the insurer's internal appeal process before allowing it to proceed further. The gatekeeper should also determine that if new information is being introduced in the claim, it should go back to the original decision-maker to see if it changes the decision before the appeal proceeds.

OSOT agrees that many claims disputes could be handled internally by rehabilitation specialists hired by insurance companies to provide advice on treatment issues and, ultimately, to prevent further escalation to the LAT; however, OSOT cautions that such appeal processes should not further delay provision of claimant benefits, but rather expedite the process.

Payment of Settlement Cheques

Marshall Recommendation #28. Settlement cheques should be made payable jointly to the claimant and his or her lawyer to allow the claimant to fully understand and accept the disposition of the funds.

The Society draws to attention that it is important to ensure that it is a responsibility of insurers to pay treatment providers in full prior to any settlement. Health care practitioners were provided the opportunity for direct billing to insurers through the HCAI system via FSCO licensing. Consequently, when treatment plans have been approved and treatment has been provided, health care practitioners should receive direct payment. Settlements should not include those treatment costs related to services already rendered. **It should be the responsibility of insurers to pay treatment providers in full prior to any settlement**.

Consumer Education

Marshall Recommendation #20. Consumer education in the field of auto insurance is a key component of a well-functioning system. In conjunction with making the rules and regulations governing the system simpler, the government should seriously address the need for enhanced consumer education. The recommendations of the Ontario Auto Insurance Anti-Fraud Task Force and the creation of an "Office of Driver Adviser" should be considered.

OSOT positions that consumer education must be ongoing. For example, the MOHLTC has recently promoted their Direct Funding program[9] by airing a commercial. This approach along with use of social media reaches a wide audience. It can be valuable to explain changes to auto insurance coverage and related topics such as: optional benefits; how to use your health expense account; what is a health care navigator and how can they help you; identifying signs of fraud; safe winter driving; distracted driving; child safety; and more. This notwithstanding, experience with the optional benefits education strategy would demonstrate that it's difficult to educate the public about components of their insurance. To this end, the system needs to be designed to user friendly, intuitive and essentially fair so that consumers don't have to be keenly aware of all details in order to be able to navigate the system and access fair benefits.

Legal Involvement

Marshall Recommendations #12 & 13.
There is clear urgency to make the accident benefits system simple and accessible without the need for legal representation. Since accident victims are in a vulnerable position and contingency-fee arrangements are not very transparent, the government should consider:
• Banning or restricting advertising and referral fees, and restricting contingency fees in personal injury cases, as the law society reports is being done in some jurisdictions such as in England, Wales and Australia.
• Requiring contingency-fee arrangements to be filed with the regulator, who should inquire into their fairness on a spot-check basis and work with the relevant authorities to curtail abuses if they arise.

[9] http://www.dfontario.ca/

• Settlement cheques should be made payable jointly to the accident victim and the lawyer. This will allow the accident victim to clearly understand the relationship between the total settlement and what he or she eventually receives.
• Claimants should be informed in writing, possibly on a final settlement schedule, of their right to appeal the fees charged by their lawyer and where to apply to do so.

The regulator should monitor the overall use of legal representation in the accident benefits system to analyze why claimants are needing to resort to legal advice. Also, the regulator should examine if the system should be further simplified, barriers should be removed or other practices changed to reduce the need for the time and expense of legal involvement.

Overall, OSOT supports a simplified method of accessing benefits and a less adversarial system, thereby reducing the need for legal involvement. We believe that this would be accomplished by introducing patient choice - by using health expense accounts and rostered independent health care navigators.

For no-fault proceedings, OSOT recommends:

- Lump sum settlements would only occur in the cases of a catastrophic claim and may or may not require the assistance of a lawyer.
- There would be a single fee paid to the lawyer for assisting with this matter; it would be unlawful to ask for more than this fee.
- The single fee would be paid by the insurer over and above the lump sum settlement awarded to the claimant.

For tort proceedings, OSOT recommends:

- The legal contingency fee should be transparent and capped
- The claimant and his/her family must understand what other disbursement fees they would be responsible to pay.
- This must be in writing.

Contingency in Tort Cases

Marshall Recommendations #26 and 27. Contingency fees in tort cases should be made fully transparent to the client, including notification that fees can be appealed.

Claimants should be informed in writing, possibly on a final settlement schedule, of their right to appeal the fees charged by their lawyer.

OSOT supports any and all attempts at transparency such that claimants are not blindsided with unexpected contingency and disbursement fees.

The Insurance Product and The New Regulator

Marshall Recommendation #18. There is an urgent need to revise and simplify the legislation and current set of regulations and focus on desired outcomes and less on the details of process.

OSOT agrees with this recommendation.

Marshall Recommendation #29. To the extent possible, the regulatory regime should be overhauled to encourage insurers to innovate and introduce new products even on a trial or experimental basis.

OSOT positions that, if insurers offer flexible insurance products to their consumers, the public interest must be protected by ensuring that the basic level of care is provided in all products.

Marshall Recommendations #31 and 32. A new, independent regulator with its own board of directors for automobile insurance be established either as part of the new Financial Services Regulatory Authority or a new separate office specifically for auto insurance.

The Insurance Act and regulations should be amended to include only broad principles and entitlements for benefits. The regulator should be responsible for interpreting the legislation and, following appropriate consultation with stakeholders, creating policies, guidelines and rules that are enforceable and not subject to challenge in the courts as long as they are in keeping with the letter and spirit of the legislation.

OSOT considers the implications of such an Authority having full power including interpretive powers. The need for some regulation changes to go through full legislative review should be commensurate with the level of risk to the public.

OSOT refers the government to other regulatory approaches used internationally such as "Right touch regulation", a standard implemented in the United Kingdom[10] or Responsive Regulation used in Australia.[11]

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[10] The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and registration of people working in health and care. We are an independent body, accountable to the UK Parliament.
What is Right Touch Regulation?

1. Proportionate: regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised
2. Consistent: rules and standards must be joined up and implemented fairly
3. Targeted: regulation should be focused on the problem, and minimise side effects
4. Transparent: regulators should be open, and keep regulations simple and user friendly
5. Accountable: regulators must be able to justify decisions, and be subject to public scrutiny
6. Agile : regulation must look forward and be able to adapt to anticipate change.

[11] "The essence of responsive regulation is listening and adapting in response to the problem we are trying to fix and to the people who can fix it. Responsive regulation is bespoke regulation, where the regulators listen to those they are regulating and choose a course of action to correct the deficiency that they are observing." http://regnet.anu.edu.au/sites/default/files/publications/attachments/2015-05/Occasional%2520Paper%252023_Ivec_Braithwaite_0.pdf

Marshall Recommendation #33. The new regulator needs to be equipped with the staff and expertise to act as a central governor over the automobile insurance marketplace including the conduct of all the players and providers within that marketplace.

OSOT positions that, if the new regulator is the body overseeing the licensing of health care practitioners in the auto insurance marketplace, then the Board of Directors should have at least one member who is a regulated health care practitioner in Ontario.

Marshall Recommendation #35. Insurance companies must change their role from managing costs to delivering care to their customers. They will need to change their claims management and related practices in the process. They will also need to innovate and compete on service and cost.

Mr. Marshall states:

> *"Insurance companies will have to equip themselves with staff who have an appropriate level of medical and rehabilitation expertise. Their front line staff must become "case managers" rather than "claims adjusters." They need to monitor the effectiveness of health care providers and give feedback to both providers and the regulator on issues or conditions which can improve care for injured persons or remove barriers to early and efficient care." (p.80)*

While OSOT understands that frontline adjusters would benefit from having some level of medical and rehabilitation training, we must ensure that "case managers" or system navigators are independent professionals who work at arms length from the insurer and the client's legal representative to avoid any perceived or actual conflict of interest. Even with this training, for many reasons, we do not believe that adjusters can *"monitor the effectiveness of health care providers"* since, in most cases, it would be outside the scope of their abilities. As well, these proposed "adjusters/case managers" would not be equipped to *"give feedback...on issues or conditions which can improve care...or remove barriers to early and efficient care."* This must be left up to the claimant's physician(s) and treatment team.

OSOT positions that an independent Health Care Navigator would be able to assist and guide the claimant through his/her treatment programming on an "as needed" basis.

Conclusion

In conclusion, OSOT agrees with Mr. Marshall's conclusion that it is time to change the way Ontario conducts the business of providing no-fault benefits to injured claimants. It's time to streamline claims management and the delivery of care to consumers without unnecessary interruptions or delays in the treatment continuum. Similar to giving consumers more choice with respect to the insurance product, such as optional benefits, it's now time to give Ontarians

more choice in their own treatment direction to the extent of their insurance coverage. We must create a system that is less adversarial, more accountable in terms of functional outcomes and more focused on claimants' ability to access the right treatment at the right time, and ultimately return to them to their pre-accident functions and life roles.

OSOT is looking forward to working together with all stakeholders in reshaping the auto insurance system in Ontario!

Addendum

Unfortunately, over the past 7 years, we have witnessed the erosion of Attendant Care & Medical/Rehabilitation Benefits as follows:

- Seriously injured claimants had their **access to Attendant Care** slashed from $72,000 to $36,000, a 50% reduction, in 2010. We knew that this would impact those who were seriously injured and who might be facing multiple surgeries and/or waiting for catastrophic designation, as they would soon run out of attendant care dollars…and this is exactly what happened.

- The **Medical/Rehabilitation Benefit for non-CAT claimants was slashed** from $100,000 (established in 1996) to $50,000—another 50% cut. Again, we cautioned government that claimants would simply run out of funds and would have nowhere to turn for their therapies…based on our experience to date, this is exactly what has happened.

- 2010 **changes removed entire benefits such as the housekeeping and homemaking benefit and the caregiver benefit** to all but the 1% of catastrophic claimants. This resulted in enormous savings for insurance companies as they now pay neither the benefit nor the costs of insurer examinations to determine eligibility for these benefits.

- Introduction of the **minor injury guideline reduced benefit access from $50,000 to $3500** for those claimants who sustain soft tissue injuries whether single or multiple. This has led to massive savings for insurance companies as 70 to 80% of claimants are served by this guideline.

Non-CAT	**Before 2010**	**After 2010**	**Proposed 2015 changes**
Minor injury Guideline	--	$3500	$3500
Med/Rehab benefit	$100,000 over 10 years	$50,000 over 10 years	$65,000 to cover both benefits, over 5 years
Attendant Care	$72,000 over 2 years	$36,000 over 2 years	
Housekeeping/HM benefit	$100 per week	Not available	--
Caregiving benefit	$250 per week	Not available	--
CATASTROPHIC CLAIMANTS	**Before 2010**	**After 210**	**Proposed 2015 changes**
Med/Rehab benefit	$1,000,000	$1,000,000	$1,000,000 to cover both benefits
Attendant Care	$1,000,000	$1,000,000	
Housekeeping/HM benefit	$100 per week	$100 per week	$100 per week
Caregiving benefit	$250 per week	$250 per week	$250 per week