Coalition

Coalition of Health Professional Associations in Ontario Automobile Insurance Services

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Elizabeth Murphy, Associated Partner
Houston Cheng, Consulting Actuary
Ahn Tu Lee, Consulting Actuary
KPMG
333 Bay Street, Suite 4600
Toronto, Ontario M5H 2S5

Thank you for your letter, dated July 5, 2014, regarding the Ontario Ministry of Finance Auto Insurance Transparency and Accountability Expert Report.

The Coalition Representing Health Professionals in Auto Insurance Reform (the Coalition) represents over 10,000 front line health professionals from over ten professions involved in the assessment and treatment of Ontarians after an auto accident.

Following is the summary of the issues highlighted in your request for feedback and comments made from members of our associations. This also includes our discussion on August 8, 2014.

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

In 2010, significant changes occurred in the Accident Benefits Schedule. These changes affected, but are not limited to:

1. Attendant care services and housekeeping benefits.
2. Minor injury determination and the $3,500.00 minor injury cap.
3. Standard benefits reduced to $50,000.00 including initiated examinations.
4. Changes to catastrophic impairment application to have physicians or neuropsychologist be the main conductors of assessments.
5. Fee cap for assessments and examinations of $2,000.00.
6. Removal of mandatory Insurer Examinations in order to deny Treatment Plans.
7. Removal of the requirement for rebuttal assessments.
8. Required use of the health claims for auto insurance (HCAI) system.
9. Use of statutory declarations.

The available data to date has confirmed that the recommendations and changes made to the policy in 2010 have resulted in drastic reductions in accident benefits. On a positive note, the utilization of the HCAI system has been valuable to provide some quantitative data, which is assisting stakeholders to make decisions based on real data instead of relying on information that was at times not substantiated.

Although not without its limitations, the Ontario Health Claims Data Base (HCDB) Standard Report, published by the Insurance Bureau of Canada every 6 months, shows us interesting information about the cost of medical and rehabilitation benefits paid by insurers. The most developed claims data, for accidents that occurred in the first 6 months of 2011, shows an average total med/rehab cost of $7495.00. This cost includes all related assessments, treatment, goods and supplies, for all manner of injuries from the most minor, to the most catastrophic.

With respect to the minor injury cap, the data provided by HCAI seems to be showing that soft tissue-related injuries are being well-contained within the minor injury definition. Looking again at the most developed claims information we have in HCDB, we see that 22.9% of all injured claimants are receiving treatment exclusively in the Minor Injury Guideline. 47.6% may have begun treatment in the MIG, but required additional treatment beyond that provided in the guideline, or otherwise were found to have an injury that could no longer be considered minor (this maps well to the 67% of claimants who were reported as having strains or sprains as the primary injury). Despite such a large percentage reporting additional treatment after the MIG, it is important to note that the average amount paid by the insurer for those receiving treatment after the MIG ($3583) is still very close to the $3500 Minor Injury cap outlined in the SABS, even though some of those claimants were surely discovered to have an injury to which the minor injury definition did not apply.

All Claimants	Accident dates January 1 - June 30, 2011				
Med / Rehab Expense Class	Number of Claimants	Percent of Total Claimants	Insurer Paid	Percent of Total Insurer Paid	Average Insurer Paid per Claimant
Treatment - Subtotal	*26,831*	*92.4%*	*108,528,683*	*49.9%*	*4,045*
Treatment - MIG only	6,646	22.9%	11,062,435	5.1%	1,665
Treatment - non MIG only	6,364	21.9%	47,943,780	22.0%	7,534
Treatment - MIG and non MIG	13,821	47.6%	49,522,468	22.8%	3,583
Insurer initiated exam	13,913	47.9%	65,686,521	30.2%	4,721
Provider initiated exam	12,813	44.1%	16,829,416	7.7%	1,313
Goods and supplies	6,006	20.7%	3,462,568	1.6%	577
Missed/Canceled appointment	6,929	23.9%	9,172,426	4.2%	1,324
Transportation	4,673	16.1%	9,565,560	4.4%	2,047
Others	3,164	10.9%	2,362,355	1.1%	747
Unallocated Amount	0	0.0%	2,017,051	0.9%	0
Total - All Expense Classes	29,036		217,624,580	100.0%	7,495

HCDB Standard Report April 2013 H2

There continues to be questions around the definition of “minor injury” and its ability to be focused on soft tissue-related injuries. Health professional associations are concerned about the risk of expansion of the minor injury definition to include psychological/mental disorders and brain injuries and other injuries that do not fall within the uncomplicated soft tissue injuries. Although there is no evidence to support whether the $3,500.00 is a sufficient amount of funding, there continues to be no opportunity for those who end up with chronic musculoskeletal pain to have

access to funding beyond the $3,500.00. The taxation model of this fee including HST has also impacted members that have to charge HST, resulting in further reduction in fees.
With respect to the cap of $2,000.00 for assessments, a majority of health care assessments can be conducted within that framework. There continues to be concern that with certain specialties, with vulnerable populations such as children, and those claimants that live in remote areas, the funding model prevents access to those most qualified to assist the claimants with proper and timely assessments.

Limitations to benefits such as housekeeping, attendant care and standard benefits reduced to $50,000.00 have affected those patients that are seriously injured. There continues to be a gap of services between those patients with minor injuries and those that are deemed to be catastrophic. Therefore, the $50,000.00 limitation in benefits has impacted those that are seriously injured, resulting in barriers to access to required health services.

The removal of a mandatory Insurer Examination was countered with the insurer having the responsibility of providing a medical reason for denial of care. Member associations do note that on many occasions, medical opinions are not generally provided or sufficient rationale is not provided regarding denial of claims. With the removal of the mandatory Insurer Examination, these assessments are often done on an arbitrary basis and not always done by peers. There are many occasions where a peer evaluation is no longer being completed and would be in the best interest of the claimant and the system and would foster dispute resolution.

The catastrophic impairment applications also changed in 2012. The legal requirement that only a physician and not a psychologist or any other health care provider may conduct an examination have caused some concerns, as they have become an arbitrary barrier to catastrophic applications for patients with mental disorders as noted by a psychologist.

2. ***Have you analyzed the impact of the 2010 Auto Insurance Reforms of your members? If so, would you be prepared to discuss your findings? Would it be possible to have the results of such quantification?***

There have been no formal surveys or data collection by the Coalition as a collective with respect to the 2010 Auto Insurance Reforms. Anecdotally, members have identified significant increases in the cost of providing care to patients in the auto insurance realm and have resulted in many practitioners opting out of service provision for patients with auto insurance claims. However, we do not have any quantifiable data. The HCAI data reports allow stakeholders to have a look at some of the costs in the system. This data in some cases provides useful information around injury types, cost of treatment services. This data should be carefully reviewed as it shows the impacts of the reforms.

The Ontario Association of Social Workers completed a survey of their members in March 2014 that looked at how the changes affected their clients and their practice. The survey indicated that:

- Two thirds of clients had maxed out their med./rehab funding;
- 100% of these clients were in need of social work services and therapy /rehabilitation services;

- 17% were able to access publically funded social work services;
- 9% were able to access publicly funded other -rehabilitation therapy services;
- 61% had exhausted non-catastrophic funding before social work goals were met;
- 56% of social workers were limiting the number of MVA clients in their case load due to the changes in med/rehab funding.

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

Since the findings of the Auto Insurance Anti-Fraud Task Force, we have observed multiple convictions that have occurred with respect to major fraud rings including staged accidents and misrepresentation of health facility billings. These results have been demonstrable and the regulators should be complimented.

During these convictions, it has been identified that many health professionals were also victims of these fraud rings. One of the recommendations of the Anti-Fraud Task Force has led to the Professional Credential Tracker tool that has been designed and has been piloted by many of our member associations. We feel the implementation of such a professional credentialing tool would be of great value and would assist members in ensuring that their health billing numbers are not being abused. We would also like to see further development of the tool so as to enhance accountability. Individual practitioners should be able to determine if billing is being done in their name.

A number of changes were also put in force on June 1, 2013 and were announced through a FSCO Bulletin #8-01-13. In these recommendations, the following are being highlighted:

1. Requiring insurers to provide all reasons for denying claims. As noted previously, insurers continue to have challenges in terms of adjudication. Health care professional associations continue to inform the Coalition that there are many claims that are being denied without any medical reasons being provided and this is resulting in additional barriers to access to care.
2. Licensing health care facilities. The main recommendation from the Anti-Fraud Task Force which will be affecting members is the licensing of health care facilities. At the present time, we are in the implementation phase and during this entire phase there has been great concern and discomfort expressed by member associations.
   In particular, it was originally recommended by the Coalition that licensing be focused on the most relevant of service providers whose business practices are not regulated already by a health professional college. We remain concerned that the licensing system is a costly duplication of regulation for those clinics owned and operated by regulated health professionals. The government, however, has determined that it is most appropriate to regulate all providers.
   Overall, our member associations are supportive of eliminating fraudulent facilities from the system. However, this additional licensing requirement, which is both a financial and administrative burden, is cause for significant concern by our members. The fee structure is

based on a cost recovery model with none of the costs being assumed by the insurers or the government. Thus while the licensing system is intended to provide savings to the system as a whole through fraud reduction, there is a shifting of costs to the health professionals. It seems that the impact of the cost of licensing, along with no increases in the professional fee guidelines over the last two years has resulted in a significant financial impact on health care facilities, in particular, sole practitioners and smaller business.

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?***

We do not have any survey results or any data to highlight any of the concerns that have been noted. The HCAI data identifies a decrease in number of claims and overall med/rehab costs. Although this does not directly relate to anti-fraud measures, this does highlight the decrease of costs in the system.

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.***

Member organizations have been regularly communicating through their distribution channels the importance of anti-fraud measures. Many of the regulatory colleges have also instituted awareness campaigns around auto insurance fraud and for members to be concerned specifically around identify theft of their names and their registration numbers. As reported above, the health professions have participated in the pilot of the professional credential tracker. There has been no formal program by the Coalition, but there continues to be dissemination of the information to different health professional associations on materials produced by the insurance companies and FSCO.

6. ***How have your members been affected by the Ontario Automobile Dispute Resolution System? Was it possible to provide a qualitative assessment?***

Some of our members have complained that the delay in the dispute resolution system have resulted in patients not receiving treatment on time and/or delays in payments to their clinics. It would be difficult to quantify these numbers. The mediation process, which until recently was significantly backlogged, is required prior to proceeding to arbitration and the insured person has virtually no remedy to address denied treatment. On many occasions, by the time the mediation arbitration decisions are made, the treatment that was originally proposed has been delayed for such a long time that the patient has developed chronic-related issues and more secondary-related issues, making the original treatment proposal irrelevant.

7. ***Have you analyzed 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?***

There has been no formal review of the dispute resolution system with our members.

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

Justice Cunningham has recommended a tiered process based on the amounts of dispute. It is this Coalition's understanding that the recommendations from Justice Cunningham will be subject to regulation, which has not been presented to date. Overall we support more timely and efficient access to dispute resolution, especially for medical benefits. We are however, concerned that the proposals will have the effect of limiting the insured person's access to dispute resolution. In consideration of dispute resolution, the severity of injury and focusing on acute needs and those with specialized needs such as children should be considered. A triage process in reviewing the disputes and identifying which priority should be considered. This may require assistance of a regulated health professional.

9. ***As part of the 2013 Ontario Budget, the government initiated auto insurance cost and rate reductions targeting the key elements of the strategy pertained to anti-fraud measures, an average automobile insurance rate reduction target of 15%, licensing of health care providers in 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 and both costs and premiums. What steps have you and your members already taken to reduce costs that would affect the automobile insurance product?***

From a health care perspective, the best way to manage fraud is to focus on best practices and evidence-based health care. Professional health care associations provide guidance and support to ensure their members are highly skilled and provide care which is most effective for the patient with a focus of returning back to independence. Our regulatory colleges have also been active in ensuring that those members within the health care system that are providing inappropriate or unnecessary treatment are appropriately evaluated and reprimanded if found to be negligent. Therefore, from a health professional's point of view, the focus has been on providing access to care that is cost effective, goal-oriented and time-limited. We also have been extremely supportive of all the recommendations made by the government and have been supported through these measures.

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

Our members will continue to work closely with the Financial Services Commission, the insurers and the Ministry of Finance to support anti-fraud initiatives. The implementation of the health facility-licensing program will be a major initiative that occurs for 2014 and will require the ongoing attention of the Coalition and support for our members.

If the Professional Credentialing system is implemented this may have an impact on fraud and associated costs. The Coalition would participate in any discussions regarding this area.

The Minor Injury Guideline recommendations will also be provided in late 2014. The Coalition will be actively involved in participating and providing feedback to the Guideline and to ensure that there is a balance between access to appropriate care and funding. This may also result in improving outcomes costs for 2015.

Some professional associations have developed guidelines related to clinical assessments and insurer examinations. All professional associations will be encouraged to do the same.

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

Issues that affect and prevent members from reducing costs include administrative burdens that have been placed on the health professionals. There is inefficiency in the system at all levels which in our view impacts access to care and sometime leads to chronicity of conditions. This does increase costs as the patients sometimes require additional care.

For those health professionals that have to travel, the costs of travelling to patient's homes for the purpose of assessment and treatment continue to increase. With the increased cost of travel including gasoline and mileage, these are difficult to be absorbed in the regular fee structure and need to be recognized as ongoing issues.

The general cost of doing business is also going up in time with funding and revenue sources remaining stagnant due to the cuts. At some point, there will come a time where it will be difficult for members to continue to provide services at the same rates as costs continue to escalate. This may present a problem for access injured accident victims to appropriate providers.

12. Are there any further actions that the government can implement to help you and your members to reduce costs that would affect the automobile insurance product?

Recommendations that can be provided by the government to reduce costs would be the following:

1. Reduce any barriers to appropriate and necessary access to services for injured victims with both physical and mental related disorders.
2. Focus on function and not just pain-related issues with the focus of allowing individuals to return back to their pre-accident levels of activity.

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

Stakeholders need to review other areas that are causing cost-related issues and not just accident benefits. Other areas that need to be focused on include:

a. Addressing the excessive costs of towing and storage.
b. Targeting accident prevention and injury reduction.

c. Utilizing telemetrics to reduce individual premiums for safe drivers and reinforce safe driving and reducing non-accident benefit cost drivers within the insurance industry.
d. Implement strategies to improve access to services. Therefore, as we continue to improve services and cost-effectiveness, members do feel that there are other areas that can be utilized to save money.
e. Improve on insurers' internal claims and adjudication processes.
f. Require Insurer's Examiners to have appropriate training and expertise and utilize professional peer reviewers where appropriate.
g. Create standards for proper adjudication including consideration of relevant evidence-based guidelines regarding assessment and treatment of both physical and mental disorders.

14. What uncertainties in the automobile insurance system are affecting you and your members?

The ever-changing regulations make it very difficult for health care professionals to plan their practices. Uncertainty on how insurers will respond to changes and interpret the regulations makes it also very difficult to manage business in this sector. Members are constantly in a position of wondering whether they will have enough income to run these businesses. The auto sector should be reminded that a majority of health care providers are small businesses and regulatory and administrative changes cause a significant burden.

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

One of the key areas that continue to be a concern is the data collection. Although HCAI has significantly improved information that is available, there continues to be decision-making occurring based on hypothetical numbers or numbers that are shared only with one organization. It would be important that data continue to be shared with all stakeholders and that future decisions in the system be made based on real data and not on any anecdotal evidence.

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?

We have not done any formal analysis of the impact of uncertainties in the auto insurance system on our members. We do not have any specific insights in this area.

17. Do you have any insights as to how these issues may be mitigated? Could you identify any actions or steps that could be taken to alleviate the uncertainty in the auto insurance system?

No specific thinking has been done in this area.

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

We do not believe that the auto insurance market place is sufficiently competitive. There continues, in our view, to be better ways of improving the system however, the entire system should be reviewed and reducing accident benefits any further in our view is not the answer.

One of the significant changes in the 2010 reform included the removal of certain benefits that then became optional for those Ontarians who were willing to "buy up" and pay extra. The intent was that Ontarians would not be forced to pay for benefits that they did not necessarily need. However, there seems to be poor communication between insurers, insurance brokers and clients when automobile insurance policies are being sold. A survey of automobile insurers undertaken by FSCO in 2011 indicated that fewer than 1.5% of Ontario policyholders were purchasing any optional benefits.

19. Have you or your members been affected by the following recent appeal of Scarlett/Belair?

The Scarlett/Belair decision and its appeal has had an impact on the definition of minor injury. The original Belair Insurance highlighted that what fell in and outside of the definition of minor injury and the compelling evidence simply meant credible evidence. There was also a feeling that the Minor Injury Guideline was a non-binding interpretive aid in deciding whether or not the insured comes within the MIG. Subsequent regulation changes reinforced that the Guidelines are binding as part of the regulations. The appeal however, disagreed indicating that the burden of proof always rests with the insured provided that he/she fits within the scope of the coverage and that compelling evidence means more than credible evidence and is relevant to the issue of pre-existing condition that may exclude a person from being restricted to the minor injury cap. We note also that an additional regulation change was made to require that the compelling evidence of the pre-existing condition must be recorded prior to the date of the accident. In addition, the concept of predominantly a minor injury was one that required further discussion.

Therefore, the Scarlett/Belair appeal decision is important to members who treat patients within the minor injury realm, especially around mental and behavioural disorders. There continues to be a concern of whether a mental-related disorder falls within the definition of minor injury where the Coalition is of the opinion that while a psycho-social issue may be addressed within the Minor Injury Guideline, a diagnosis of a psychological disorder would exclude an individual from the minor injury definition.

Pastore v. Aviva.

There were concerns from the insurance industry that the Pastore v. Aviva would result in a significant increase in the number of catastrophic claims. The Pastore decision now affirms that a person must have a marked impairment due to a mental or behavioural disorder in order to satisfy the catastrophic impairment criteria. This has, in our view, resulted in an increase of a very small number of individuals found to have a catastrophic impairment due to a mental disorder.

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Henry v. Gore Mutual.

In reviewing the appeal of Henry vs. Gore, the appeal judge focused on the fact that the amount of services that would be paid for would be that which was on Form 1. Subsequent to that, the government has brought in a requirement regarding incurred expenses.

In our view, there are a very limited number of individuals who qualify for attendant care with the new regulation and it seems contrary to the purpose of insurance turning to professional providers in these cases as problematic. It should be stressed that all attendant care services are subject to insurer approval. Insurers are able to control whether any services are provided and if offered, how many hours of service is provided.

Thank you for allowing us the opportunity to provide feedback to your organization.

Sincerely,

Dr. Moez Rajwani
Co-Chair

Dorianne Sauvé
Co-Chair