Coalition of Health Professions in Auto Insurance

November 29, 2024

Mr. Glen Padassery
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Dear Mr. Padassery,

Re: FSRA Auto Insurance Reform Reviews

On behalf of the Coalition of Health Professions in Auto Insurance (the "Coalition"), I would like to thank you for the opportunity to respond to the Financial Services Regulatory Authority of Ontario (FSRA) reform reviews on the Statutory Accident Benefits Schedule (SABS) Guidelines (which includes the Professional Services Guideline, the Attendant Care Hourly Rate Guideline, and the Minor Injury Guideline), Health Service Provider Framework and the Health Claims for Auto Insurance (HCAI) Systems. We welcome FSRA's efforts to create a modernized and sustainable auto insurance system for Ontarians injured in auto accidents. The Coalition appreciates your commitment to modernizing the auto insurance system to improve access to benefits and affordability for consumers in Ontario.

The Coalition was formed in 1990 with a membership of eight regulated health professional associations.[1]These Associations, in turn, represent over 40,000 regulated health professionals involved in the assessment and treatment of Ontarians injured in motor vehicle accidents (MVAs). The Coalition brings an important perspective -- shared across multiple health disciplines -- on the needs of claimants and consumers in a viable and sustainable auto insurance system in Ontario. Over more than three decades, we have actively participated and engaged in meaningful developments and reforms through our work with the Financial Services Regulatory Authority of Ontario (FSRA) presently, its predecessor, the Financial Services Commission of Ontario (FSCO), and the Ministry of

[1] The Coalition is comprised of the following member Associations: Ontario Association of Social Workers (OASW); Ontario Chiropractic Association (OCA); Ontario Dental Association (ODA); Ontario Physiotherapy Association (OPA); Ontario Psychological Association (OPA); Ontario Society of Occupational Therapists (OSOT); Registered Massage Therapist's Association of Ontario (RMTAO); and Speech-Language & Audiology Canada (SAC).

Finance (MOF) and the Ministry of Health.

1 STATUTORY ACCIDENT BENEFITS SCHEDULE (SABS) GUIDELINES REVIEW

1.1 PROFESSIONAL SERVICES GUIDELINE (PSG) CONSULTATION

Comments and Recommendations

The Coalition supports and commends FSRA's stated guiding principle of reviewing the PSG to maintain the care consumers receive while ensuring that health service providers (HSPs) are appropriately compensated.

Since 2014, neither the PSG (or the MIG) have been reviewed, amended, or increased. As a result, regulated health service professionals (HSP)s working in the auto insurance system to provide care for patients injured in motor vehicle accidents are in their 10th year without a fee increase. During this same period, the cost of operating a business has increased significantly, making it difficult for regulated health professionals as small business owners to continue providing these services.

Consequently, we strongly recommend indexing the PSG (Option A) with the following caveats and recommendations:

i. The existing base hourly rates for regulated HSPs on the PSG should be negotiated in good faith between FSRA and each professional Association representing the regulated HSP listed on the PSG. Thereafter, indexation of these rates should be provided on an annual basis with continued collaboration with professional Associations and should not only account for changes to the Consumer Price Index (CPI), but also cost of living (which is not the same as inflation), and changes to market rates.

ii. Given the length of time the PSG has been neglected, negotiated changes in the base rates should be implemented fully and applied retroactively to July 01, 2025 (and may need to be applied retroactively if FSRA changes occur after this date). A staggered approach should not be considered.

iii. There should be a mechanism for other professions to be added to the PSG when the respective professions desire it.

iv. The word "maximum" should be removed from the description of hourly rates for both catastrophic and non catastrophic impairments as the PSG does not preclude insurers from paying above the maximum rates set on the PSG.

v. The PSG should be amended to include a statement clarifying that services provided by a regulated HSP (whether or not the regulated HSP is listed on the PSG) are to be paid by a regulated HSP's professional designation and not be the services they provide. This statement is currently presented in two FSCO Bulletins; however, the License Appeal Tribunal (LAT) adjudicators have deemed that these Bulletins do not form part of the regulation and are, therefore, not binding. Having this included within the PSG will provide clarity and will substantially eliminate the possibility for disputes on this issue and prevent the need for adjudication on these issues at the LAT.

PSG Consultation Questions

1. If PSG rates are indexed (Option A), what should they be indexed to and why?

The Coalition recommends that existing base hourly rates for regulated HSPs on the PSG be negotiated in good faith between FSRA and each professional Association representing the regulated HSP's listed on the PSG. Professional associations are in the best position to evaluate and discuss rates on behalf of their members that are reasonable, fair, and well-premised for the Ontario market. Thereafter, rates should be provided on an annual basis, based on the Consumer Price Index.

We believe regulated HSPs working in the automobile insurance sector should be paid fairly for the critical and high-quality rehabilitation services they provide by the Statutory Accident Benefits Schedule (SABS). The PSG has not been reviewed, amended, or increased since 2014. As a result, current PSG rates no longer reflect reasonable and customary market rates for the services provided by regulated HSPs in this sector.

Another aspect of the PSG that contributes to unreasonably low rates is outdated and incomplete information on professional regulation. For instance, the standard educational requirement for occupational therapy changed from a Bachelor's to a Master's degree in 2008 and, for physiotherapy in 2012. Registered Social Workers have remained excluded from the PSG despite their recognition in the SABS as a regulated health profession, and claimant's frequent access of their services for mental health care, case management, and other roles.

If the PSG continues in its current form and is not revised in a fair and timely fashion, including a resetting of the base fees and indexation, the Coalition expects the following will continue:

- Loss of qualified regulated HSPs to other sectors
- Pressure on the public health and social care system arising from lack of/timely access to necessary rehabilitative treatment providers with resulting poor recovery outcomes
- Increasingly limited access to regulated HSPs in rural, underserved, and vulnerable populations
- Increased challenges for claimants to access necessary and mental health care
- Continued disputes at the LAT regarding fees for professions not listed on the PSG (particularly, registered social workers)

2. **If PSG are moved to flat rates (Option B), how should those flat rates be determined and why?**

   The Coalition does not support this option.

3. **Should rate increases (Option A or Option B) be staggered incrementally over a few years, or should it take place at once?**

   Since the PSG has not been updated since 2014, bi-laterally negotiated changes in each profession's base rates should be implemented fully and applied retroactively to July 1, 2025, as soon as possible. A staggered approach should not be considered.

4. **Should FSRA review fees regularly, and if so, at what frequency (i.e. annually, biennially etc.)?**

   The Coalition recommends that fees for form completion be reviewed biennially.

5. **For Option C how often should insurers/HSPs meet to review/set maximum rates?**

   The Coalition does not support option C.

6. **Are there other options/considerations related to rates/fees that should be considered for the PSG?**

   Regulated health professionals working in the accident benefits sector serve varying roles within their respective scopes of practice when providing services to claimants. For example, an occupational therapist may provide vocational counselling; occupational therapists, nurses, and physiotherapists often provide case management services as part of their role. As such, the PSG should clarify that services listed in the PSG and supplied by a regulated HSP (regardless of whether the regulated HSP is listed on the PSG or not) are to be paid by a regulated HSP's professional designation and not be the services they provide. In doing so, the Coalition submits that FSRA will substantially eliminate the possibility for dispute and prevent the need for adjudication on these issues at the LAT.

7. **Do you have any evidence that consumers are having difficulty obtaining the HSP care they need due to the existing PSG rates?**

   The Coalition member associations increasingly report that their membership of sole practitioners and clinics operating in this accident benefits sector either substantially decreases the percentage of motor accident benefits cases they accept or are actively pursuing surrendering their FSRA license altogether.

   Increasingly, regulated health professionals across the sector are choosing to leave the automobile insurance sector due to the low hourly rates paid under the PSG. Although the Coalition does not have specific data, members of Coalition Associations who provide case management services to persons with catastrophic impairments report that it is becoming increasingly difficult for claimants to access qualified practitioners in their community who can provide the necessary rehabilitation services, particularly for psychological services/mental health care and, increasingly, occupational therapy. Moreover, the hourly rate for Registered Massage Therapy services has historically been substantially

below the actual market cost. Most claimants are thus financially prohibited from accessing this form of care.

8. **What are the key implementation considerations that must be taken into account for each option (i.e. timing, updates to billing systems, etc.)?**
   See Section1, Comments and Recommendations.

How can FSRA help to ensure that any changes to the PSGs are communicated to HSPs, insurers, consumers and other stakeholders?

See Section 1, Comments and Recommendations.

9. **Are there other considerations which have been missed that should be taken into account as part of the PSG review?**

   (See # 6 above).

1.2 ATTENDANT CARE HOURLY RATE GUIDELINE (ACHRG)

Comments and Recommendations

Attendant care benefits, an integral part of the auto insurance product in the province since the inception of the no-fault accident benefits system, provide injured claimants with necessary help for their personal care and basic home-hygiene needs after an accident. A lack of access to care creates risks for delayed recovery, increased complications, exacerbation of symptoms, further injury, and at times, risks to individual health and safety.

Unfortunately, Ontarians injured in motor vehicle accidents who require attendant care (and the case managers and health professionals who coordinate their care), face myriad barriers and challenges in accessing these necessary and critical services. Among the root causes of this problem are five related issues:

1) The hourly rates listed on the Form 1 (which are prescribed for the calculation of the attendant care benefit have not changed since 2016 (for levels 1 and 3) and 2018 (for level 2) and do not, in any manner, reflect the actual reasonable and customary market rates that claimants need to pay for the care they require. It is understood that the low prescribed hourly rates on the Form 1 are purposefully set so that the quantum benefit calculated would only partially pay for the attendant care hours required by a claimant. However, stagnation of the rates has meant that claimants have experienced increasing difficulties in receiving the actual hours of care that they need.

2) Based on LAT and Court decisions (e.g. Malitskiy vs. Unica) and despite previous FSCO Guidance regarding the inappropriateness of doing so, some insurers and their subsidiaries are inappropriately using the Form 1 hourly rate to pay for services provided by care agencies. The disparity in the hourly rates has effectively resulted in the claimants of these insurers being, a) completely unable to use the attendant care benefit to purchase the care they need, or b) being required to co-pay the difference between the Form 1 hourly rates and the reasonable and customary rates of the care agency, which becomes a significant cost-burden for the claimant.

3) The statutory maximum attendant care benefit of $3000 and $6000 per month have not increased since November 1, 1996. However, the reasonable and customary costs for the services provided by care agencies has, by necessity, increased. Resultantly, the purchasing power of the attendant care benefit has eroded, and claimants are now receiving an estimated 40% less hours of care than they did in 1996.

4) Use of the Form 1 as the tool for calculating the attendant care benefit gives rise to high levels of variability in how an individual's attendant care needs are assessed and, resultantly, inconsistencies in the quantification of a claimant's attendant care benefit. This leads to challenges for ensuring claimant's care needs are adequately met and disputes between the claimant and their insurer which are referred to the LAT.

5) Contradictory information provided to claimants concerning the attendant care benefit and their assessed attendant care needs as presented on the Form 1 (in hours) misleads claimants into believing that they will receive more care than what they are actually entitled to due to the low hourly rates used in calculating the attendant care benefit, which, as already mentioned, does not reflect the market rates needed to purchase required care from community care agencies.

Note: *See **Appendix A** for an overview of the evolution of the attendant care benefit in Ontario and the existing challenges related to this benefit*).

The Coalition believes that claimants injured in motor vehicle accidents must receive timely access to the attendant care benefits they require. Likewise, we believe that health service providers, including personal support workers and other caregivers, who provide attendant care must be paid fairly for their services, just like regulated health professionals under the PSG.

As such, we strongly recommend that:

i. Insurers' payment of the attendant care benefit to care agencies must be based upon reasonable and customary hourly rates.

ii. Should the Form 1 continue to be the assessment tool used to determine the quantum of the attendant care benefit (and recognizing that, in doing so, the resulting quantum is not intended to fully compensate a claimant for the full value of the costs of the care they require), we recommend that FSRA should:

   a. Increase transparency for consumers so that they understand that the attendant care benefit is intended to only partially contribute to the costs of the care that claimants require after involvement in a motor vehicle accident

   b. Prohibit insurers from using the Form 1 hourly rates (used to <u>*calculate*</u> the benefit) in the payment of attendant services to a care agency, and issue companion instruction to insurers as soon as possible.

   ~~c.~~ Increase the hourly rates on the Form 1 that are used to <u>calculate</u> the benefit. At minimum, Form 1 level 2 hourly rates should be set to, and continue to follow changes in, the minimum hourly rate for Ontario. Levels 1 and 3, at minimum, should be raised from their current 2016 hourly rates to a rate that would be based upon the CPI having been applied each year between 2016 and up to and inclusive of the effective date that the hourly rate changes would apply.

   d. <u>Ensure that hourly rates for the attendant care benefit are negotiated in good faith between FSRA and personal support workers/care agencies. Thereafter, indexation of these rates should be provided annually based on the CPI.</u> *(Note: PSWs will soon be able to apply for registration with the Health and Supportive Care Providers Oversight Authority and with successful registration, they will be considered a regulated care professional under the Health and Supportive Care Providers Oversight Authority Act.*

   e. <u>Raise the maximum monthly attendant care benefit limits of $3000 and $6000 to allow claimants to access the required hours of care. These maximum limits should also be indexed on an annual basis based on the CPI.</u>

f. Review Form 1 usage for calculating the attendant care benefit and consider other potential methods for determining how to evaluate and provide benefits to meet individuals' attendant care needs to ensure clarity and greater transparency concerning the evaluation and payment of the benefit, and assessment reliability.

g. If the Form 1 Assessment of Attendant Care Needs is maintained as the tool to calculate the attendant care benefit, FSRA should consult with occupational therapists and nurses to develop and provide instruction and improved guidelines for assessors who complete these evaluations.

ACHRG Consultation Questions

1) How should Level 1 and 3 (Option B) attendant care rates be indexed?

Please see Section 1.2, Comments and Recommendations.

2) Should Level 1 and 3 rate increases (Option B) be staggered incrementally over a few years, or should it take place at once?

Please see our Section 1.2, Comments and recommendations.

Should FSRA review the rates of all three Levels regularly, and if so, at what frequency (i.e. annually, biennially etc.)?

Yes, these rates should be reviewed regularly, and it is recommended that they be reviewed on an annual basis.

3) Are there other options/considerations related to rates/fees that should be considered for the ACHRG?

Yes. Claimants must not be led to expect a certain number of hours of PSW only to discover their insurance covers much less due to agency overhead costs taking away from their allotment. The hourly rates paid by insurers to agencies for attendant care services must be inclusive of both the amount the agency takes to cover overhead costs, and the fees paid directly to PSWs to ensure claimants are supported for their needs.

4) **Do you have any evidence that consumers are having difficulty in obtaining the attendant care they need (Level 1-routine personal care and Level 3-complex health/care)?**

Although the Coalition does not have specific data, members of the associations of the Coalition report that due to the issues described in our submission, above, claimants are experiencing significant difficulty obtaining the full hours of attendant care that they need (due to the low hourly rates and statutory maximums) and, in some cases, claimants due not receive any attendant care services due to insurers inappropriately restricting payment of the benefit to rates identified on the Form 1, which are to only be used in the calculation of the benefit.

5) What are the key implementation considerations that should be taken into account for each option (i.e. timing, updates to billing systems etc.)?

See Section 1.2, Comments and Recommendations

6) **How can FSRA help to ensure that any changes to the ACHRGs are communicated to HSPs, insurers, consumers and other stakeholders?**

   Please see Section 1.2, Comments and Recommendations.

7) **Are there other considerations which have been missed that should be taken into account as part of the ACHRG review?**

   Please see Section 1.2, Comments and Recommendations.

1.3 MINOR INJURY GUIDELINE (MIG) CONSULTATION QUESTIONS

Comments and Recommendations

The Coalition supports the original goals of the MIG as set out in 2010. A simplified administrative regime, with pre-approved funds and block fees for a set of health services for consumers whose injuries are predominantly minor, speeds access to rehabilitation, improves healthcare resource utilization, and creates certainty around cost/payment for regulated HSPs and insurers, alike. However, since 2014, neither the Minor Injury Guideline (MIG) nor the Minor Injury Cap (MIC) have been reviewed or updated. As a result, in today's dollars, Ontarians have less coverage than they had a decade ago -- and healthcare businesses in this sector (often small- to medium-sized clinics) are also finding it hard to meet increased operational costs of business.

Accessing the funds under the Minor Injury Cap requires nonessential approval processes (for care that exceeds $2,200.00), coupled with insurer denials and partial approvals. These processes create barriers to care for motor vehicle accident claimants with minor injuries and generates backlogs at the Licence Appeal Tribunal (LAT).

Consequently, we recommend indexing the MIG (Option A) with the following caveats and recommendations:

i. A simplified process for accessing the remainder of the minor injury cap ($1300) should be established to ensure a timely continuum of care and reduce disputes.
ii. The MIG should be indexed with an annual cost of living adjustment using the Consumer Price Index (CPI) and a one-time retroactive top-up for 2025.
iii. Block funding under the MIG should be revised in consultation with regulated health professionals who extensively use the MIG to ensure adequate flexibility in the 12-week timeframe to support patient needs and health outcomes.
iv. To ensure timely communication regarding changes to the MIG, FSRA should work with professional associations and maintain its usual communication channels (e.g., email bulletins, newsletters, and official websites).

MIG Consultation Questions

1) If MIG rates are indexed (Option A), what should they be indexed to and why?

See Section 1.3, Comments and Recommendations. The Coalition strongly recommends that SABS benefits be annually indexed to inflation to ensure that the overall resources available to claimants do not decrease year over year. This annual indexing is required at all benefit levels.

At the same time, all three benefit levels (i.e. the Minor Injury Cap, non-catastrophic and Catastrophic limits), under the SABS, have not changed since 2014. As a result, in today's dollars, Ontarians have less coverage than they had a decade ago – and healthcare businesses in this sector (often small- to medium-sized clinics) are finding it hard to meet increased operational costs.

2) **Should rate increases (Option A) be staggered incrementally over a few years, or should it take place at once?**

A retroactive cost-of-living increase using the CPI should be applied all at once.

3) Is the existing block fee structure/amounts for pre-approved MIG treatment appropriate? Why or why not?

Block Fee Structure:

Since the inception of block funding, initially designed in 2010, regulated health professionals across Coalition member associations have identified that the same number of sessions typically occur in each block, even though provider reimbursement decreases across blocks 1 to 3.

Many healthcare providers identify the same number of sessions may occur in each block[2], yet the amount of reimbursement is different. The flexibility of how funds are spent in the 12-week timeframe needs to be reviewed.

Pre-Approved MIG Treatment:

The MIG for simple soft tissue injuries allows the consumer immediate access to treatment funding without insurer interference. Presently, this occurs for the MIG ($2200). As indicated in Section1.3 Comments and Recommendations, the Coalition recommends that a simplified process to access these funds should occur for the remainder of the minor injury cap ($1300) to ensure a timely continuum of care and minimize debates.

4) **Should FSRA review MIG rates regularly, and if so, at what frequency (i.e. annually, biennially etc.)?**

FSRA should review MIG rates biennially.

5) Are there other options/considerations related to rates/fees that should be considered for the MIG?

When multiple injuries occur, there are no mechanisms to provide additional care except for supplementary goods. This has been reported to be insufficient funding for an injured claimant that has suffered multiple soft tissue injuries.

6) Do you have any evidence that consumers are having difficulty obtaining the HSP care they need due to the existing MIG rates?

In a recent Coalition survey, two-thirds of regulated health professionals working in the auto insurance sector reported that Ontario's Minor Injury Cap is insufficient to meet the health care needs of claimants with minor physical injuries. This leaves many without needed care or facing delays in care to access further benefits beyond the Minor Injury Cap.

[2] The current block fees funding are as follows: Initial Fee: $215; Block 1-$775.00; Block 2-$500.00; Block 3-$225; Supplementary Fees: $400 Discharge OCF-24-$ 85

7) **What are the key implementation considerations that must be taken into account for each option (i.e. timing, updates to billing systems, etc.)?**

The one administrative issue is the use of employer based extended health care for minor injuries. The Coalition expects this will be addressed based on the government's commitment to make Auto Insurance a first payor. However, we are collectively disappointed that implementation of this provision is deferred to July of 2026.

8) **How can FSRA help to ensure that any changes to the PSGs are communicated to HSPs, insurers, consumers and other stakeholders?'**

Communicate directly with all Licensed HSPs and work closely with Professional associations to share information with their members.

9) **Are there other considerations which have been missed that should be taken into account as part of the MIG review?**

Programs of Care:

The Coalition has been participating in development and review of programs of care in auto insurance since the introduction of the Whiplash and Associated Disorder (WAD) protocols in 2003. These include the Pre-approved Framework (PAF), and the Minor Injury Guideline (MIG).

In addition, the Coalition supports the following principles regarding the development and use of Programs of Care, which we believe should guide the exploration and implementation of any changes to the MIG:

- Best practice as well as current scientific evidence
- Providing a guideline rather than being prescriptive in treatment protocols to allow for health care provider expertise and patient choice respecting all three components of evidence-based care
- Requiring ongoing re-evaluation based on new and emerging evidence-based practice
- Collaborative development with the health care provider groups representing the professionals who will implement them
- The patient population it serves regarding type, severity, and concurrence of injuries and pre-existing conditions
- Timely access to treatment while removing barriers to timely care
- Reducing administrative burden
- Decreasing the adversarial nature of adjudication experienced within the insurance context
- The present experience with MIG has led to many disputes and misunderstandings of the definition.

2 HEATH SERVICE PROVIDER (HSP) FRAMEWORK (LICENSING) REVIEW

Regulated health professionals in Ontario have Colleges that regulate their professional practice, including standards related to billing practices. As a result, FSRA licensing is duplicated, leading to confusion and transparency issues regarding accountability. Further, many regulated health professionals focus only a small part of their practice on auto claims. FSRA's licencing process continues to add unnecessary time and financial burdens.

To reduce red tape and costs in the system without sacrificing public protection, we recommend that:

i. FSRA licensing, including registration processes, should be streamlined with costs lowered for regulated health professions to recognize existing regulatory oversight.
ii. FSRA retain full licensing processes and costs only for the businesses owned by non-regulated health professionals.

1. **What features should an HSP licensing system focus on to have better user functionality?**

   As stated above, the HSP licensing system should be streamlined in recognition of existing regulatory oversight. To avoid duplication, a modernized licensing system should rely on existing, publicly available Regulatory Health College (RHC) registry data on the Health Service Providers (HSP), such as the following: name, practice locations and business name(s), business contact information, and license standing and restrictions, where applicable. HSP license numbers are often partially redacted, so collecting this information will require consent.

   Although some of this information is publicly accessible, a data-sharing agreement between the RHC and FSRA with member consent to participate in the licensing process is highly recommended for transparency between FSRA and its members. The data collected by the licensing system should interconnect with the HCAI system to a) reduce redundancy in reporting by HSPs and b) reduce administrative errors in reporting, resulting in improved efficiency and functionality.

2. **Are there any concerns/considerations FSRA should keep in mind when developing and implementing the HSP Supervisory Tool?**

   Yes. As regulated healthcare professionals, we fully support a transparent and accessible database and analytics strategy to oversee the auto insurance industry. To that end, the Coalition would like to be involved in designing and implementing (both new and existing) data collection, data analysis and reporting processes that underpin any HSP Supervisory Tool. Additionally, regulated health professionals should have access to both data reports and databases to conduct analyses and inform practice management and care. Ontarians should also have access to data on claims-handling practices to support informed decision-making when purchasing accident benefits.

3. **What areas of licensing and supervision can RHCs and FSRA work together on to better alleviate issues in the sector?**

   RHCs have a statutory mandate to register and regulate HSPs in Ontario. With this mandate comes the responsibility to limit licensure, impose terms and conditions or further disciplinary action, when in the public interest. From an administrative justice and fairness perspective, regulated HSPs are exposed to restrictive, redundant reporting and regulation processes between their Colleges and FSRA. Outcomes for college reports and investigations related to auto insurance fraud should inform FSRA's licensing and supervision processes, and the RHCs should be consulted on advancing this model.

4. **What are the key implementation considerations that must be taken into account for each initiative (i.e., timing, communication, education, etc.)?**

   As stated in our response to Question 2, the Coalition supports a transparent and accessible database and analytics strategy to oversee the auto insurance industry. To that end, the Coalition would like to be involved in designing and implementing (both new and existing) data collection, data analysis and data reporting processes that underpin any HSP Supervisory Tool. Further, to increase efficiency in data sharing and licensing, FSRA should collaborate with health professional regulatory colleges and professional associations.

5. **How can FSRA help to ensure that prioritized initiatives / changes are communicated to HSPs and other stakeholders?**

   The Coalition and its participating regulated health care professional Associations can partner with FSRA in communicating upcoming changes and be trusted sources of education and dissemination. Public-facing education is also a very important consideration and is a core role for FSRA in conjunction with regulated health colleges and professional Associations.

6. **Are there any considerations which have been missed that should be considered as part of the HSP review and/or the proposed initiatives?**

   We believe that the HSP Framework and HCAI reviews should be viewed from a holistic perspective. For example, HSPs (and motor vehicle accident claimants) should be permitted real-time access to services provided (or received) to reduce the risk of abuse in the system. Further, we recommend that the use of the Credential Tracker be resumed. This tool permits HSPs to see which healthcare facilities have registered their credentials to bill insurers in the HCAI system. The HSP is then able to report any concerning activity to HCAI. This process should be further developed to allow health professionals and patients to check all applications and invoicing in their name in real time.

3 HEALTH CLAIMS FOR AUTO INSURANCE (HCAI) SYSTEM REVIEW

Comments and Recommendations

The Coalition supports FSRA's efforts to modernize the Health Claims for Auto Insurance (HCAI) system to create a more streamlined and efficient process for managing health claims. Guided by the principles of standardization, fitness-for-purpose and responsiveness, a modernized HCAI system can reduce red tape and administrative burdens on HCAI end-users, improve communication among insurers and regulated HSPs, and ensure cost-efficient and effective delivery of health care benefits to Ontarians injured in motor vehicle accidents.

To create a modern, efficient, and effective HCAI system, the Coalition recommends that FSRA:

i. Establish a mechanism or Working Group for stakeholders to improve the operational effectiveness of HCAI.
ii. Conduct a comprehensive review of the current HCAI system with a view to confirmation of the Health Intervention Codes which are considered reasonable/necessary.

HCAI Consultation Questions

1) Which initiative(s) should be prioritized? Why?

FSRA should establish a mechanism or Working Group for stakeholders to support and enhance modernization efforts. We recommend that FSRA's first priority should be establishing such a mechanism or forum for stakeholders to improve the operational effectiveness of HCAI. The forum should include HCAI end-users along with insurance adjusters. The Forum's terms of reference should include advising FSRA on key outcome data/improvements to existing HCAI forms.

As all three FSRA Auto Reform Review initiatives are related, an established group could efficiently provide integrated recommendations. This approach would support the ultimate goal of modernization by creating a system with a simpler process to manage health claims and provide regular data to ensure decisions on future products are based on proper data analysis.

2) Are there any significant benefits/drawbacks, including potential stakeholder impacts, missing from the analysis set out above that should be included?

We believe the HCAI Reform Review consultation should adopt a holistic view of HCAI as an integrated component of a revised HSP Licensing system. For example, when a common registration occurs, HCAI should facilitate a seamless and simpler experience with data sharing to fill all subsequent fields and forms. The system should also permit HSPs (and motor vehicle accident claimants) to track in real-time healthcare services provided (or received), thereby reducing the risk of abuse in the system.

3) **Are there any considerations which have been missed as part of the analysis set out above that should be included?**

As part of efforts to improve the HCAI system's operational effectiveness, the Coalition recommends a comprehensive review of the coding system (including Health Intervention Codes) to determine, among other things, which codes are reasonable/necessary and whether additional educational resources might be required to ensure codes are understood and used correctly. This work can be undertaken as part of the HCAI form review.

To improve claims adjudication and overall administrative efficiency, we recommend that the HCAI tool enable more effective communication between insurers and HSPs/patients. Better use of existing comment fields for interactive dialogue and automated notifications would help reduce and resolve disputes more quickly (e.g., a notification to signal when a claim has been approved or whether an Independent Examination has altered a claims decision).

We believe the planned review of the forms should be guided by principles of standardization, fitness-for-purpose, and responsiveness, and the following three overarching recommendations:

- First, we believe FSRA should issue prescribed standard documents for all forms and standardized definitions for key terms and concepts. Such uniformity will ensure that claimants – and those who assist them – can easily and readily understand and complete documents.
- Second, OCFs should require only information to conform to a form's stated purpose. Streamlining in this manner will reduce burdens on claimants and build consumer confidence in the overall claims process and auto insurance product.
- Third, insurers (and FSRA) must have a clear obligation to respond to the diverse needs of consumers and claimants. To this end, the Coalition supports an online chat function, and a toll-free support line provided by FSRA (or another neutral entity) to provide information and guidance to consumers and claimants. Such supports are critical to accommodate the diverse needs of Ontarians (which include, for instance, varying degrees of English language proficiency and literacy), and help injured claimants navigate what is often a highly stressful and vulnerable time

4) **What are the key implementation considerations that must be taken into account for each initiative (i.e., timing, communication, education, etc.)?**

As we have noted, there is a need for comprehensive, accessible shared data. We recommend developing a more thorough, accessible database to give the government and all stakeholders to have information regarding utilization, costs, and outcomes to evaluate how the system meets their priorities and concerns. This information could inform the evaluation of how the system meets their priorities and concerns.

5) **How can FSRA help to ensure that prioritized initiatives / changes are communicated to HSPs, insurers, and other stakeholders?**

There are opportunities to directly communicate with HSPs through E-Blasts and other initiatives undertaken in collaboration with professional associations and regulatory colleges, which are well-positioned to engage their members. It is also recommended that Q&A be used to engage with clarity.

6) **Are there any other opportunities for administrative and cost efficiencies that FSRA should consider to make the HCAI system more modern and efficient that are not included in the list of initiatives above?**

The HCAI and Licensing systems should be reviewed holistically to support modernization goals.

Thank you again for providing this opportunity for feedback. We look forward to collaborating with you to support the implementation of planned reforms to modernize auto insurance and enhance the provision of health care benefits for Ontarians injured in motor vehicle accidents.

Regards,

Dr. Moez Rajani and Kim Doogan, Coalition Co-Chairs