Ontario Society of Occupational Therapists

Response to Ministry of Finance Consultation

Putting Drivers First – Care not Cash Default
Putting Drivers First - $2 Million Catastrophic Impairment Default Benefit Limit

September 16, 2019

The Ontario Society of Occupational Therapists (OSOT) represents over 4,500 occupational therapists (OTs), who are regulated health care professionals, working in the province of Ontario over 600 of whom work in the automobile insurance sector. Occupational therapists in the auto insurance sector provide a valuable service in identifying dysfunction, whether physical, cognitive, behavioural or emotional, and providing treatment to restore function. OTs are trained in both physical and mental health and can identify the early signs of depression, anxiety and chronic pain. OTs are one of two professions listed in the SABS who can assess personal care needs and complete the Assessment of Attendant Care Needs Form 1. Occupational therapists are instrumental in facilitating the insured's return to home, work, school and community roles.

This paper addresses the two consultation documents issued by the Ministry of Finance – the proposed $2 million Catastrophic Impairment Default Benefit Limit and the Proposed

Proposed $2 million Catastrophic Impairment Default Benefit Limit

The Ontario Society of Occupational Therapists (OSOT) supports the government's proposal to amend a regulation that would, by default, provide every policyholder (and other insured persons under the policy) with a $2 million benefit limit for medical, rehabilitation and attendant care benefits, if catastrophically injured in an auto accident. The commitment to retain an aggregate amount to cover medical, rehabilitation *and* attendant care benefits is important to provide accident victims the flexibility to access the type of care they need, and in the way that they need it.

The proposal that there be an option for consumers to purchase less coverage at a lower premium meets a threshold of consumer expectation of choice, however, contradicts the government's

rationale for increasing the benefit coverage – *"Gaps in consumer awareness and understanding, or changes in personal circumstances, can result in drivers selecting insufficient coverage, particularly with respect to catastrophic impairment benefit limits*." We would agree that given a choice for a "cheaper" option, many consumers will choose a lower coverage without considering the value and protection they would be giving up. We question whether this might undermine the potential to more effectively support those with catastrophic injuries through the proposed increased benefit and cannot support this option.

Question 4: What potential benefits or implementation challenges should the government consider regarding the proposed approach?

Necessary to support Meaningful Rehabilitation and Life Long Supports

Catastrophically injured insureds represent less than 1% of those injured in automobile accidents each year. While the proposed change doubles the benefit, occupational therapists have observed the challenges that catastrophically injured insureds have experienced in trying to accommodate their needs since the $1 million benefit limit was imposed. We would assert that the proposed increase is *necessary* to support meaningful rehabilitation and necessary life long supports for insureds with catastrophic injuries.

OSOT does not foresee any implementation challenges except those that currently plague the system in general such as arbitrary denials leading to long waiting periods to obtain needed treatment/benefits and lengthy dispute periods, even for those who are catastrophically injured.

Access to and Determination of Cash Settlements

We note and support that cash settlements remain an option for insureds with catastrophic injuries. Settlements should be made available to such persons at any point during the claim, in fact, earlier rather than later to enable them to manage their own care and costs as they see fit and to maximize investment returns on their settlement which may help funds go further. When there is no tort claim, early settlement of the SABS claim is particularly important since the insured must preserve as much of his/her $2 million as possible for his/her future care needs. Early settlement (i.e. occurring no sooner than the two-year mark) minimizes the insurer's ongoing administrative costs and eliminates the potential for and costs of ongoing disputes and independent assessments relating to treatment proposals.

Determination of an appropriate settlement may be challenging if the insurer is not prepared to pay out the remainder of a claimant's $2 million policy limit. If a dispute arises as to whether an insured is entitled to the full $2 million to manage his/her present and future care, OSOT

recommends that an objective Life Care Plan be accessed to help to settle this type of dispute. A Life Care Plan requires a "neutral" assessor with unique expertise and specialized training. Many occupational therapists take extra training to be certified as a Life Care Planner as the demands of a LCP fit well within the scope of practice of occupational therapy. It should be noted, however, that a Life Care Plan can take upwards of 60 hours to complete as it requires a comprehensive review of the historical file documents, and interviews of the insured, his/her caregivers, family and all the treating health professionals along with an extensive report of costs. This cost should not be expensed as part of the insured's medical/rehabilitation benefit.

Clear and appropriate definition of Catastrophic Impairment

Changes to the CAT designation criteria in 2016 have resulted in many more seriously injured insureds who do not meet the threshold for CAT designation as they might have in the past. OSOT recommends that FSRA review claims data to determine how many people exhaust the $65,000 med/rehab benefit. This would give an indication as to whether the new definition is too restrictive. This threshold of eligibility will become even more significant when the differential in access to benefits is $1,935,000.

Question 5: What potential implementation costs should government consider regarding the proposed approach? Who will bear those costs? For example: a) Impacts to average premium for consumers b) Impacts to administrative costs for industry stakeholders c) others?

OSOT does not have access to data that would support analysis of the cost/savings impact of this increase in benefit for insureds with catastrophic impairments or costs to insurers and the system in general.

The Society submits that early settlement of the SABS catastrophic files would reduce the costs for insurers by reducing the administrative costs to the system and the consumer. Though the proposed change significantly increases the potential benefit paid out, this would be offset by insurer savings in claims management, avoidance of ongoing disputes, etc.

In claims that are not settled, it might be assumed that with a larger benefit limit there is potential for multiple challenges to treatment plans over a longer period of time that could increase assessment costs and significantly diminish the claimant's experience of the auto insurance system. This would be important for FSRA to monitor.

Question 6: What measures could be considered that would avoid unnecessary disputes and/or litigation costs?

OSOT supports the goal to minimize disputes and/or litigation costs. There must be fewer arbitrary denials of treatment plans and fewer insurer examinations. Strategies to be considered include:

- opening up communication between the insurer and the treating health professionals (Treatment Team) to facilitate sharing of perspectives, rationales, mutual understanding etc. that may minimize dispute
- achieving more consistency and standardization in the referral and assessment process (e.g. training programs for assessors, standardized forms, specific questions in referral, etc.)
- development of a systemic structure to enable neutral, objective, unbiased assessments
- early settlement of the SABS file.

Question 7: Should MVACF claims be subject to the $2 million default benefit limit?

We understand that access to the catastrophic benefit limit is based on need. In principle, therefore we would suggest that an MVACF claimant that has the same diagnosis/impairment that a non-MVACF claimant has would have the same needs and the same need for coverage. This would seem particularly fair for the innocent pedestrian hit by a car driven with no insurance or a hit and run situation.

Question 8: What additional changes could the government consider to achieve and/or support the stated policy objectives? What are the risks, opportunities, and costs associated with these other approaches?

Option to purchase $1 million coverage

Government proposes that providing an option to purchase a lower threshold of coverage for catastrophic impairment would provide consumer choice. While this may be true, OSOT would assert that the risk is that people make uninformed choices. Current consumer practice tells us that people seldom "buy up" for increased coverage. Hence, if there is an option to pay "less", it is worrisome that people will make a choice based on dollars without understanding the implications of reduced coverage. We perceive this option will continue to leave those insureds with catastrophic injuries with insufficient funds for meaningful rehabilitation and lifetime necessary supports.

Reducing Assessment Costs by Reducing the Number of Assessments – achieving neutrality in the 3rd party assessment system

A significant cost factor in the auto insurance system is the cost of assessments when there are disputes about treatment approaches or an insurer's denial. The number of assessments is often inflated because an insurer's assessor will be challenged by the lawyer with their own assessor because of their perception that the insurer's assessor is biased (or vice versa). The potential for bias is real when an assessor's income is tied to their referral source. Achieving a system that assigns a neutral assessor that both parties can trust for an objective assessment could eliminate significant cost of duplicative assessment that prolongs a claimant's timely access to treatment. OSOT has long supported a rostered system of qualified assessors who meet defined standards and expectations and who are assigned randomly when a third party assessment is required.

Provide access to immediate funding for treatment to a limit for all insureds

Implementing the $2 million catastrophic impairment default benefit limit is expected to "provide more Ontarians more coverage, so accident victims can get the treatment and care they need more quickly." It is not clear how access to $2 million will support access to treatment more quickly. Past experience would suggest that this is not a valid premise as insureds incurred delays in access to treatment awaiting insurer exams, etc. when they had $2 million before.

OSOT recommends that insureds with serious and catastrophic injuries have access to a set amount of funding which they can access to begin treatment immediately without having to gain approval. This would achieve the goal of getting treatment earlier. Insureds with minor injuries access $3500 without approval, why shouldn't those with more serious injuries have the same benefit? This would eliminate any initial disputes before the claimant is even able to get to treatment.

Proposal for Care not Cash Default Clause

Occupational therapists (OTs) are supportive of the principles behind a "care not cash" approach to accident benefits following an MVA. As rehabilitation professionals, OTs are vested in contributing to the restoration of an insured's function and ability to return to normal activities of daily living. This we believe, can best be achieved by timely and uninterrupted access to rehabilitation services and benefits.

The Society supports the recommendation that those insureds who have catastrophic injuries continue to have the option to negotiate a cash settlement. These individuals will have lifelong needs for supports and a cash settlement (after a period of rehabilitative care) can enable these catastrophically injured to best manage and maximize their resources through investment.

The restriction of any cash settlement is not without concerns as this may impact the insureds relative power and rights within the system and disproportionately empower the insurer.

These themes are explored further below.

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

Occupational therapists observe that claimants are most likely to seek a cash settlement when they experience repeated challenges to the treatment plans submitted by their health care providers and their experience of both their claim's management and the interruptions to their rehabilitative process is less than positive. In such cases claimants are more likely to seek legal advice and representation and to advocate for a settlement that will enable them to manage their rehabilitation themselves. There are situations where adjusters reach an impasse with claimants, their family caregivers and their treatment team and cannot agree on the treatment needs/path forward or where an insurer may challenge treatment plans with an Insurer Exam that results in disagreement between the treatment providers and those opinions expressed by an Insurer Examiner(s). A cash settlement may be sought by the insured to;

- Allow the insured to move forward in his/her treatment and/or pay those treatment providers whom have been paid out-of-pocket for services already rendered.

- Provide the insured with some peace of mind.

An adjuster may be motivated to offer a cash settlement to close his/her file and reduce ongoing administrative costs.

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

OSOT identifies the following strategies that could facilitate earlier dispute resolution;

- Establishing a minimum benefit entitlement that can be accessed without insurer approval.

- improved communications between the insurer and the insured and the insured's health care team, e.g. perhaps using a Chat feature within the HCAI system. When an adjuster is uncomfortable with a treatment plan, the opportunity for timely and efficient communication with the health professional can provide for the clarification of the reasoning behind the treatment proposal and prevent dispute of the plan.

- Training/orientation and development of best practices for adjusters. Formal orientation including background on common injuries and usual treatment approaches could reduce denials.

- Reform of the current Insurer Examinations (IEs) processes to achieve a more neutral assessment could significantly reduce disputes that emerge from "duelling assessments" from insurer and legal assessors.

- Ensuring that if an IE is required, it is completed by a like professional with provision for communication between the assessor and treating health provider. This assures that the assessor has the professional background to both understand the assessment and treatment approaches proposed by the treating provider. Expecting the assessor to communicate with the treating professional can assure that the insights of the treating provider can be taken into consideration in the assessor's evaluation.

- Providing for continued treatment while an IE is being requested and implemented. This minimizes the disruption and discontinuity of treatment which the treating provider deems necessary until an IE has been completed.

- Adherence to set deadlines re timely response of the insurer following an IE.

- Proposed treatment plans should include rationales: details about the goals and outcomes expectations related to the specific goods and services being proposed. A review of the OCF forms should be undertaken to incorporate modifications that would enable space and a requirement for the Treatment provider's rationale for treatment recommendations so that these are clear to the adjuster. This would reduce denials based on insufficient information or rationale. can understand the recommendation and avoid disputes.

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

- Persons receiving care out of province may need the cash as care providers will not be able to bill through HCAI.

- OSOT supports the recommendation that insured who have Catastrophic designation should be exempted from the restriction on cash settlements. Consideration of whether settlement could be enabled at the time of application for Catastrophic Impairment designation (OCF19) could advance a settlement sooner and eliminate the significant assessment costs associated with catastrophic determination. However, the needs of paediatric claimants must be managed under different timelines from adult claimants. While in some paediatric cases CAT determination can be made early in the process, it often takes years to see the impact of their injuries as children "grow into their injuries". Early settlement could result in insufficient funds to provide appropriate treatment and care for the child as their limitations emerge as they age with their disabilities.

- In some cases, an insured who is seriously injured may have longstanding rehabilitative needs (i.e. more than a year) that might best be managed by the individual through a settlement which would also allow the insurer savings on claims administration. In such cases, OSOT suggests consideration of an option that would allow the insurance company to offer a "settlement", the amount of which is applied to the insured's Driver's Care Card or his/her account as a credit which can be used by the insured to purchase health care services and/or equipment by an FSRA/HCAI-licensed provider.

The credit on the insured's account would have the same expiration time as the insured's Medical, Rehabilitation and Attendant Care Benefit, i.e. 5 years (or the remainder of the benefit period). Equipment would have to be prescribed by a FSRA/HCAI-licensed provider. This modified "settlement" would continue to support the principle of "care not cash", ensuring the funds would be utilized for medical/rehabilitation benefits.

OSOT proposes that in situations requiring determination of the quantum of the "credit settlement", an occupational therapist with experience in future health projections prepare a specialized assessment called a *Functional Rehabilitation Funding Plan* that addresses the costs of future treatments aimed at returning the insured to his/her functional roles within the remaining years of the insured's claim. This neutral assessment will assist both parties in determining a settlement credit value which is realistically required by the insured in accessing future care and rehabilitation equipment to ensure functional restoration. The insured should be able to hire a lawyer to obtain Independent Legal Advice (ILA) which is funded by the insurance company when negotiating a fair credit for the insured's claim.

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

Consumers are generally focused on the coverages of their car insurance only at the time of renewal as this is linked to pricing. It would seem prudent to tie any change to a default of care not cash and the introduction of an optional benefit that would enable insureds to negotiate a settlement at the time of policy renewal. This would require implementation over a year long period to accommodate renewal dates. OSOT would assert that these changes require critical attention to consumer awareness and understanding so as to ensure that informed decisions can be made at the time of policy renewal.

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

Addressing the power imbalance in the auto insurance claims management system
In the current system, there is a power imbalance between the insurance company and the insured who is seeking treatment. The current system allows the insurance adjuster to either wholly or partially deny a Treatment and Assessment Plan (OCF-18) submitted by the insured's treatment provider which creates a dispute between the parties. The insured may (or may not) be asked to undergo an independent assessment by an insurance-rostered physician or therapist, however, this may result in further dispute. Currently, the insured can hire a lawyer to represent his/her case at a LAT. Without the promise of a cash settlement, most insureds would be unable to pay for the services of a lawyer and would be unable to represent themselves at a LAT. This magnifies the power and control of the insurer and does not necessarily result in faster treatment or reduced treatment denials.

Assuring Access to Legal Representation when Needed
In the event of a dispute going to the LAT, the insured should continue to be able to hire a lawyer to obtain independent legal advice (ILA) with those legal costs being covered by the insurance company. This might discourage insurers from indiscriminately denying OCF-18s. Perhaps the government should consider capping those legal or paralegal costs when assisting a non-CAT insured at the LAT.

Concerns re consumer inability to fully understand the variable of an optional benefit purchase to enable negotiation of a settlement
At the point of premium coverage purchase, typically the individual is aiming for the lowest insurance premium. For the insured who has never had a claim for personal injury, she/he will not likely have considered the benefits of care versus settlement. The notions of 1) purchasing an option to settle and 2) the premise of care not cash are principles of the auto insurance product that would need to be clearly explained.

Question 7: What terms, conditions, limits, or other factors should the government consider in designing a cash settlement optional benefit for Non-CAT?

The proposed cash settlement optional benefit presents a number of challenging considerations including;

- The recommendation to move to a "care not cash" option is presumably based on the evidence that would suggest that timely access to rehabilitative care leads to best functional outcomes after a motor vehicle accident. The notion of offering an option to do something different than this, confounds the premise of the "care not cash"

approach to auto insurance medical/rehabilitation benefits.

- Past experience regarding public uptake of optional benefits that incur additional cost to their auto insurance premium would suggest that optional benefits are seldom purchased.

- Should a person pay to be able to receive a cash settlement, what mechanism/process will be in place to ensure he/she uses the settlement funds for the recommended treatment/aids/equipment rather than for other uses?

  If they are going to receive cash rather than care, we suggest the claimant should have to undergo a minimum period of assessments and treatment (2 years) funded through the SABS before they are able to "cash out". This we believe will help to reduce risk of fraud.

As identified above, insureds tend to seek cash settlements when they are dissatisfied with their claim experience, have become fed up with the system and want to reduce the stress of too many denials of treatment plans, too many assessments, onerous processes, and feeling that they are not improving or receiving the treatment they need. If measures to minimize the number of disputes and assessments are successful, we believe the average insured is actually more interested in getting better and getting on with their life and the interest in seeking settlement could be diminished.

While OSOT supports that care should be given, rather than cash, we have proposed an option that could provide a credit for care for non-CAT insureds.

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

If the government chooses to proceed with Cash not Care default and the proposed optional cash settlement benefit, a well-defined campaign to inform the public of the rationale and principles upon which the auto insurance med/rehab benefits are delivered (care not cash) is needed. This should include orientation to the processes which are in place to assure timely access to care with minimal dispute (i.e. Insureds need to understand how the system is supposed to work). Education needs to be culturally sensitive, accessible and at a readership

level appropriate for the general public. Some specific examples of educational options include:

- Text descriptions in multiple languages that are easy to understand (e.g. targeting a grade 6 level of education)
- Videos in multiple languages (clinicians could provide videos outlining what insureds should consider)
- Calculators that show not only the cost savings on the purchase of the policy but also the potential costs of benefits
- Testimonials (these should be endorsed by the not-for-profit organizations representing injured parties e.g. OBIA, SCIO, FAIR, etc.)

It can be assumed that most purchasers of insurance will want to understand what they get if they pay more for the benefit of being able to access a cash settlement. Providing meaningful information in this regard may be difficult because the reasons one might wish to settle may relate to the number of assessments, denials, etc. that are generally experienced. We are not aware that this data is available or that insurers would wish to share this data.

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

Should the government decide that insurance companies will be required to open up a portal system for their customers, and the portal can be accessed by the insured directly after an accident, there is an opportunity to provide educational resources on the portal that provide information and answers to common questions about what to do after a motor vehicle accident in consumer friendly language. Topics such as the following could be addressed:

- How do I get treatment?
    - How to find a therapist/doctor.
    - How to get the insurance company to pay my therapist.
    - How much money is available for my treatment?
    - How do I find out how much money I have left for specific benefits?
    - Etc.
- Does my insurance company have to pay for any treatment that I ask for?
    - What is covered?
    - How do I get it approved?
    - What if the insurer denies something that I think I need?
    - Etc.
- What is a dispute?

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

The Ontario Society of Occupational Therapists is supportive of the principle of Care not Cash and believes that in a less adversarial auto insurance system this principle could be applied well, resulting in faster access to care, fewer treatment plan denials, reduced costs in assessments and an increase in spending on timely care that is necessary.

We assert, however, that settlements should remain an accessible option for persons with catastrophic injuries.

We remain concerned that the elimination of cash settlements from non-CAT insureds could result in an unfair balance of power to the insurer in that without the promise of a settlement the insured's potential to seek legal representation in the event of a dispute may be limited because they do not have the financial resources to pay.

To this end, the Society would recommend consideration of settlements for non-CAT insureds that are extended as credit to their claim account and available to be used only for the purposes of purchasing necessary care and/or equipment at their discretion from a FSRA/HCAI registered provider.

In a settlement situation, the insured should be able to use the credit to purchase necessary care and/or equipment at his/her discretion and without unnecessary delays.

Enabling cash/credit settlements allows the insurance industry the administrative and cost benefits of settling/closing a file. This notwithstanding, we appreciate that in a credit settlement situation there would need to be measures in place to manage the credit account. As the system moves ever more digital this could be a reasonable expectation.

In summary OSOT supports:

- The principle of Care not Cash
- Cash settlements for CAT insureds
- For non-CAT insureds, in most instances, the Medical, Rehabilitation and Attendant Care Benefit should provide for care rather than cash, however, a "credit settlement" could

be negotiated and “credit” applied to the insured’s account solely for the purchase of med/rehab benefits.

- A less adversarial system where legal representation is reduced, however, when required, the non-CAT insured should be able to hire a lawyer to obtain independent legal advice to ensure they are getting a fair settlement, with those legal costs being covered by the insurance company.

Thank you for the opportunity to provide input to this consultation. The Society would be pleased to provide further clarify on any of out points should this be of use. Please contact Christie Brenchley, Executive Director at 416-322-3011 or cbrenchley@osot.on.ca.