CANADIAN SOCIETY OF CHIROPRACTIC EVALUATORS

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December 1, 2013

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On behalf of the Canadian Society of Chiropractic Evaluators (CSCE) I would like to thank you for the opportunity to submit on short notice comments on the Interim Report on the Ontario Automobile Insurance Dispute Resolution System Review.

CSCE is a not-for-profit organization representing chiropractic expert doctors who perform third-party independent assessments. Our mission is to maintain and enhance a high level of quality in independent assessment and the resultant report. Members provide work within public health insurance programs, workplace insurance plans, and within the private sector.

We would agree with the interim paper that the Dispute Resolution process has become unnecessarily protracted and costly system. CSCE recognizes that the Interim Report deals with Dispute Resolution (DR) in broad terms and most specifically on the mediation and arbitration processes. However, **we would like to point out that dispute resolution process is a continuum that begins when an application for benefits is denied by the insurer**. Further, any dispute resolution process must incorporate best practices. We would note that the more substantive issues with the entire DR process were precipitated with regulatory changes in 2006 and 1010 which are discussed below. These changes saw the elimination of the Designated Assessment Centre process, the arbitrary cutting of accident benefits to levels that cannot be substantiated by either the medical or scientific literature, the elimination of significant portions of the Unfair or

Deceptive Acts or Practices (UDAPs) Regulation and the empowering of insurers to be able to arbitrary deny benefits without appropriate rationale. These Regulatory changes have dramatically resulted in insurer profitability to previous unprecedented levels. The issues have been further compounded by an anemic and haphazard management style at the Financial Services Commission of Ontario that has done little to address the problems in a timely manner. Time and money is spent regulating health care providers, whereas the mandate for FSCO is to regulate insurers.

CSCE would agree that there are abusers in the system but would note that abuse comes from all the stakeholders groups. We would fully support a zero tolerance policy for this type of behaviour by any stakeholder. However, our experience has been that efforts to curtail abuse have focused exclusively on treatment providers and claimants with some focus on legal representatives and very little to no focus on insurer practices. Regulatory and Superintendent Guidelines has made the provision of appropriate and cost-effective medical and rehabilitation services to legitimate claimants by ethical healthcare providers untenable which has led to a substantial increase in disputes.

The Problem – in Part

We would like to address some of the comments made within the Interim Report. One comment made was that the previously Designated Assessment (DAC) system for addressing disputes was too costly. There is no support for this comment. The elimination of the DAC system was strictly a result of a Liberal Party's 2004 Pre-Election White Paper commitment. This commitment was an effort to garner election support from insurers who wanted greater control to deny benefits and claimants/service providers/legal representatives who wanted the elimination of a neutral assessment system that they felt unreasonably denied access to benefits. The elimination was not supported by the Superintendent of the day who recommended some reforms to the system to make it more effective.

The Interim Report notes that there was a significant increase in costs from 2006 to 2010, with no information provided as to what occurred in 2006 that may have led to this increase. The sole substantive change to the regulations in 2006 was the elimination of the DACs. With the elimination of the Designated Assessment Centres (DACs) in March 2006 the following occurred:

1. Independent assessment costs rose from $53 million through the DACs (numbers tracked by FSCO) to over $400 million (insurer reports of assessment costs),
2. Overall claims costs went from $5.4 billion to $8.7 billion,
3. SABS benefit costs went from $1.8 billion to $4.5 billion,

4. Independent examination opinions no longer binding on the parties pending mediation/arbitration,
5. No standardization for independent examination processes in the system,
6. 100/107 former DAC facilities no longer in business despite the government's written assurance of a role for these facilities (many of which were hospital based)
7. Independent assessment services now concentrated to a handful of companies.
    a. Many are foreign owned providing services province wide and were active lobbyists of the Liberal Government for the elimination of the DACs in pre 2006, and
8. Loss of a valuable tool in the identification of insurance fraud.

Further, regulatory changes in 2010 weakened/eliminated much of the Unfair or Deceptive Acts or Practices regulation which has further contributed to disputes leading to an increase in mediation/arbitration. In particular changes include:

9. Peer assessment is no longer required and assessment by an individual who has the education, training and experience to perform the assessment,
    a. Contrary to the Government's own reforms with respect to the Rules of Civil Procedure – Section 53,
    b. Assessments being performed by a higher portion of individual's who do not have the appropriate education, training or experience,
10. The cost of individual assessments has not decreased significantly and for Assessment Centres to generate profit has led to reduce fees paid to qualified assessors.
    a. This has led to the most highly trained and experienced assessors leaving the system, contributing to more disputes due to greater bias in assessment opinions.
    b. This increased bias and the elimination of rebuttal opinions has led to increased disputes and applications for mediation/arbitration.
11. Insurers increasingly denying benefits without an appropriate expert, peer healthcare opinion.
12. Longer delays in reports due to no regulated timeframes for "expert" opinion reports, resulting in chronicity for susceptible patients.
13. Timelines for assessments are prohibitively long due to selection/utilization bias in assessors by insurers and assessment companies.
    a. Utilization of medical specialists who are in short supply who often do not maintain a balanced practice between clinical and assessment work – the "hired gun" that flies around the Province providing services.

As side notes, we would like to make the following comments:

14. The Interim Report states that there are over "100" companies delivering auto insurance in the Province while in actual fact many of these companies are owned by the same parent company and the majority of policies are delivered by a handful of them.
15. The Interim Report states that there was a decrease in the number of accidents reported in the Province between 2006 and 2010. This may be a false assumption as there was a change in the mechanism of how the Ministry of Transportation reported accident and injuries and in the threshold for reporting injuries.
16. The Interim Report states that few consumers are purchasing an optional benefit which is true as the optional benefits are subject to the same rule as a lower benefit. For example, if one purchases additional coverage for treatment benefits, they cannot be accessed if one has a minor injury.
17. The Interim report notes a decrease in Arbitration numbers in the post 2010 reforms but fails to note that there was an introduction of a two-year rule before an application could be filed. This indirectly leads after the denial of a benefit in the development of chronicity of injuries in a claimant resulting in higher costs at settlement or the hope that a legitimate claimant will "just go away."

The Solution – In Part

Notwithstanding recommendations for addressing the backlog and streamlining the process with regard to Mediation/Arbitration, we recommend that once a medical and rehabilitation/disability benefit is in dispute that a fair, neutral early assessment process be implemented. The following principles should be followed:

1. Allow for a multidisciplinary assessment at 26 weeks to determine the need for ongoing benefits
    a. The current $3500 cap coupled with no opportunity for independent assessment at end of MIG is a major factor in mediation applications due to the potential for the development of chronicity, and "gap" patients who have no benefit,
    b. Assessments should be on a peer review basis and should be done by an assessing specialist with the requisite skill sets gained through advanced education, training and experience to provide an opinion,
    c. Assessments should be done from a roster of assessing specialists maintained by FSCO rather than by insurer or plaintiff controlled assessment facilities,

d. Assessing specialists could align themselves with assessment facilities to handle the administrative aspects of independent assessment,
e. Assessments should be done on a regional basis using regional assessing specialists rather than the current practice of some independent assessment companies of flying assessors into a region to perform assessments,
f. Exception to this rule should be only where there is no regional assessing specialist available to perform the assessment or to perform it within an six week period,
g. Roster should focus on assessors who have the necessary skill sets and are healthcare specialists rather than general practitioners (i.e. medical specialists, chiropractic specialists, advance diagnosis physiotherapists, practical nurses, etc.),
h. All assessing specialists should be required to take an approved course through an accredited institution of higher learning in the art and science of independent assessment and the current regulatory framework in Ontario,
i. Exception to the 26 week rule for an independent assessment is for potentially serious psychological and physical issues identified by accident victims health care providers but assessment is done by an appropriately qualified roster assessing specialist,
j. Assessing specialists performing Catastrophic Impairment assessments should be required to be certified in the AMA Guides to the Evaluation of Physical Impairment,
k. Assessing specialists should be required to maintain yearly continuing education and current certifications with respect to independent assessment,
l. Opinions of multidisciplinary assessment should be binding on parties pending further Dispute Resolution,
m. Outcomes from independent assessor's opinions would be recorded through HCAI with yearly reviews to remediate or eliminate those assessors who are overly plaintiff or insurer biased,
n. The assessment process utilizing roster assessment specialists is integral to the complete dispute resolution process.

2. Unfair or Deceptive Acts or Practices regulations should be strengthened and expanded with increased penalties for insurers, legal representatives, healthcare professionals or claimants who "abuse" the system
    a. Rostered assessing specialists should have the ability to report suspected cases of inappropriate behaviours to an a new multi-stakeholder advisory committee,
    b. Advisory committee would review cases of inappropriate behaviours and refer cases on to appropriate regulatory bodies for further review,
    c. Ownership of rehabilitation facilities providing accident benefits should be strictly restricted to regulated health professionals only,
    d. Penalties as outlined in the Provincial Offences Act need to be clearly defined within the Regulation.

Others will have comments regarding contracting out dispute resolution services to the private system, and hybridization of the mediation and pre-arbitration system. What is essential is that any system that is developed look to ensure that those injured persons legitimately entitled to benefits receive those benefits in a timely fashion, while at the same time provide assurance for ratepayers that dispute costs are not driven up unnecessarily by expensive tort and mediation/arbitration proceedings. Any dispute resolution system must adopt best practices.

CSCE would welcome the opportunity to further discuss in detail our comments and recommendations. I can be reached at david.dossantos@trilliumhealthpartners.ca or directly at 416.737.4842.

Sincerely,

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