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RESPONSE TO THE INTERIM REPORT

ON THE ONTARIO AUTOMOBILE INSURANCE

DISPUTE RESOLUTION SYSTEM REVIEW

November 29, 2013

OVERVIEW

In general, the Ontario Rehab Alliance finds the Interim Report to be a well-informed, thoughtful, balanced and articulate analysis of the current Dispute Resolution (DR) system. Our association supports many of the preliminary recommendations though we are looking forward to greater insight into what implementation might look like.

Our reading of this report and the comments that follow reflect our perspective as the only association which focusses solely on the needs and experiences of the auto insurance sector's healthcare providers, and the clients that they serve.

Founded in 2009, the Ontario Rehab Alliance is an association representing more than 90 healthcare organizations with over 4000 healthcare professionals including physicians, neuropsychologists, physiotherapists, occupational therapists, speech language pathologists, chiropractors, psychologists, social workers, nurses, rehabilitation support workers, personal support workers and case managers. It is these professionals who are the primary providers of healthcare and rehabilitation services to the 65,000 Ontarians who are injured each year in automobile accidents.

TREATMENT – RELATED DISPUTES

The frequency of treatment-related disputes highlights the impact of this system on our members.

We were interested to note [p.12] that treatment is the most commonly disputed issue and that: *"the top disputed categories for closed mediation files between January 2006 and August 2013 were:*

- *Medical and rehabilitation benefits*
- *Assessment and examination expenses (conducted by the claimant's health care providers)*
- *Housekeeping and home maintenance expenses"*

We are appreciative of the report's clarification that: *The frequency of housekeeping and home maintenance expenses as a disputed benefit have dropped off because they are now only available to policy holders who purchased optional coverage (1.4% of policy holders) or are catastrophically injured (1% of victims).*

INCREASED APPLICATIONS & DECREASED INJURY VOLUMES [p. 20]

The Interim Report notes that: *"Although the number of injuries arising from auto accidents as reported by the Ministry of Transportation dropped in the period from 2007 to 2010, the number of mediation applications nearly doubled…this coincided with sharp increases in benefit utilization, including medical and rehabilitation benefits…"*

This seeming anomaly is frequently noted in the ongoing discourse on auto insurance reform, and is most often linked to a supposition of opportunistic and/or fraudulent activities on the part of health providers, claimants and claimant representatives**. However, there is rarely any mention or exploration of the alternative cause for the rise in claim volumes relative to injury volumes: the erosion of publically-funded rehabilitation.** The period of 2004-2010 was characterized by a steady withdrawal of OHIP-funded services that were previously utilized by injured parties. These now-vanished services include: chiropractic services, (delisted in December 2004) and outpatient physiotherapy services, (delisted in April 2005 for all but those over 65 yrs. of age, not on social assistance or just released from hospital). Those few still eligible for OHIP-funded physiotherapy faced long wait times for service in many parts of the province. This picture was further darkened by a sharp decline in CCAC-funded home care therapy and hospital out-patient rehab. This retreat from publically funded rehab services continues, illustrated by the changes to availability and access to physiotherapy announced as recently as August 2013. Further, the period of 2004 – 2010 was characterized by a rise in the number of 'orphaned' patients, Ontarians without a family physician.

Further, we suspect that auto accident figures may not paint a complete picture of volumes. Based as they are on Ministry of Transportation data, these numbers are unlikely to reflect injuries only noted by injured parties following an accident, and who may consult their physicians or a hospital emergency department in the day or two afterwards. Some symptoms do not present immediately or only become worrisome when they do not abate.

We believe that the rise in the number of disputes requiring mediation and arbitration is due to the fact that currently two of the foundational aspects of auto insurance – profitability and consumer protection - are seriously out of balance since implementation of the 2010 cuts.

Data available from the General Insurance Statistical Agency (GISA) makes it abundantly clear that auto insurance, and in particular Accident Benefits, are now highly profitable.

- The positive impact of the 2010 changes on insurer profitability is just starting to be reflected in the numbers:
    - In 2012 the loss ratio for Accident Benefits (AB) in Ontario was 44. This means that out of every $1 in premiums collected with respect to AB, only 44 cents was paid out, leaving 56 cents on the dollar toward the insurers' bottom line. It is crucial to note that the 2012 Loss Ratio in Ontario was the lowest one in Canada;
    - In real dollars terms, the data shows that Ontario insurers' AB costs have dropped from a high of $3,775,193,778 in 2009 to a dramatically lower $1,676,520,138 in 2012 – a decline of 68%! ;
    - Based on the above numbers, if the insurers cut their premiums by 15% the AB Loss ratio would settle at a very profitable 52% (from 44% in 2012).

These profits have been at the expense of those injured.

In the spring of 2013 the Ontario Rehab Alliance conducted a survey of health professionals working in the auto insurance sector to amass data on the impact of changes made in 2010 to Accident Benefits. The findings are sobering:

- Only 20% of seriously but not-catastrophically injured victims are attaining their rehabilitation goals since the reforms of 2010, as compared to 60% before September 2010.
- Prior to September 2010, 42% of injured clients could achieve *half* of their pre-MVA (motor vehicle accident) function. Now only 26% are able to attain this level of recovery.

These statistics reflect a dramatic decrease in functional participation and meaningful contribution to family, work and community.

The 2010 changes have led to a dramatic increase in denial rates. This observation has been substantiated by the findings from a survey conducted by the Alliance and the Coalition of Health Care Provider Associations in September 2011. The denial rate of applications for the assessment and treatment of motor vehicle accident victims, (i.e. Section 25 Assessment OCF 18s and Treatment Plan OCF 18s), in the period after September 1, 2010 had increased by 158% and 141% respectively as compared to the period prior to September 1, 2010. Specifically, the average reported rate of denial (comparing pre-Sept 2010 period to post-Sept 2010 period) for Assessments had increased from 12% to 31% and for Treatment from 12% to 29%.The above evidence reinforces the point that arbitrary decision-making and aggressive claims handling by insurers are significant contributors to claimant frustration and DR volumes.

TIMELINESS [P. 24]

We commend the Interim Report for noting the importance of timeliness in dispute resolution, and in particular, the observation that: "The lack of timeliness has an impact on the system and participants beyond just delayed resolution of claims. Obtaining funding to pay for treatment becomes a challenge. "

We support the recommendation to establish delivery standards with respect to timeliness. Delays in approval result in assessment and treatment delays that can have dire consequences for injured parties. Prompt assessment and timely, appropriate treatment have been clinically demonstrated to expedite rehabilitation and recovery. Past delays of many months in duration while awaiting mediation resulted in undue harm to those injured and eroded confidence in the system and the Accident Benefit scheme.

PROPORTIONALITY [p.25]

A future system that could accommodate different processes based on the complexity of the case – an expedited process for simple cases or those where the benefits in dispute are below a monetary threshold - This lines up with our Association's thoughts re a 'triaged' approach as suggested in our initial submission. However, we raise some cautionary notes with respect to this approach:

- While paper reviews are an attractive concept due to their expeditious and cost-effective nature, there are a number of implicit limitations with paper reviews that we believe should be factored into a remodeled system.

- The suggested $25 000 threshold is much too high for the value of a disputed benefit to achieve before the dispute proceeds to a 'higher, more intensive level of DR.' This threshold would disqualify almost all hearings of disputes other than claimants with Catastrophic injuries or matters related to the Income Replacement Benefit. This will leave claimants with severe Non-Catastrophic injuries unable to access in-person hearings for serious matters relating to their

healthcare needs. Alternatively, a threshold of $ 5 000 would accomplish the goal of proportionality without constructing an additional barrier to accessing benefits.

PREDICTABILITY - CEASING PUBLICATION OF ARBITRATION DECISIONS [P.27]

We support the Interim Report's caution in regards to the insurance industry's suggestion that arbitration decisions not be published. We believe that arbitration findings ***must*** be made publically available if the auto insurance system is to achieve any degree of the oft-touted goal of transparency.

NEUTRAL MEDICAL OPINIONS [P.28]

We are intrigued by the notion of exploring the possibility of providing arbitrators with access to independent medical consultants (not IE assessors) to view files and provide opinions on appropriate treatment to provide arbitrators with neutral benchmarks for generally-expected treatment and recovery times. The report, very rightly, ponders the central question of how to find medical consultants who will be considered neutral by all the users of the system. We would need to think more about the credential thresholds, as well as roles and accountability of neutral medical consultants throughout the various proposed levels of the remodeled DR system (e.g., internal review, insurer examination, DR), before providing further comment.

STREAMLINING & THE ROLE OF HEALTH PROVIDERS IN DR [P.29]

We appreciate the Report's validation, in response to suggestions that providers should somehow be barred from using the system, of the need for health care providers to access the DR system.

The Report makes the important observation that, currently: *Health providers are permitted to bill insurers directly, but there is no formal process available to them to dispute denied accounts.* Our association has frequently raised this issue with FSCO, and believe that it must be addressed as FSCO's role is expanded to that of our sector's regulator and service provider licensing is implemented. We support health providers having direct access to DR in order to resolve matters relating to collection of outstanding and overdue accounts.

We concur with the Report's comment that: *The provider is in the best position to communicate an explanation of why the denied services are reasonable and necessary.* However, we do not think it is advisable or viable for health care providers to initiate the DR processes in order to 'defend' proposed treatment plans. This is outside of the scope of health care providers: they are care providers, not litigants. Further, most lack the resources that would likely be required to obtain legal representation or the skill set to represent themselves. Nor would it make financial sense for them to spend time and/or money to 'earn' the entitlement to provide treatment. For instance, the legal cost incurred by treatment providers to dispute a denied $2,000 treatment plan may end up costing the same.

CULTURE [P.31]

We are struck by the Report's observation that: "*Although I sympathize with the insurance industry's desire to close files on a full and final basis, I find the practice in some circumstances counter-productive. It only encourages the type of behaviour insurers have raised…* "

The report goes on to state: "We concur with *extending the one-year prohibition in settlements if it would have an impact on the "cash for treatment" mentality that currently exists."* We are in favour of shifting the culture away from a "cash for treatment" mentality, and strongly believe that Accident

Benefits should be used as intended – for treatment and rehabilitation. However, we are mindful that such a shift could have counter-intuitive and unanticipated negative consequences for claimants if changes to the DR system to accomplish this culture shift are made without full consideration of the possible impacts, and without reference to the fuller context of the auto insurance system as whole, grounded in the SABS and their accompanying Regulations. In fact, we see a possibility that if not properly designed such a move may lead to an increase in the denial of treatment and a corresponding increase in the utilization of the DR system, leading to an outcome exactly opposite from the one intended.

MANDATORY MEDIATION [P.33]

Philosophically, we are in favour of a DR system, such as the Report suggests, *where the front end contains a more evaluative and involved intervention and one in which non-compliance by the parties must be addressed early on*, as we believe that this will assist in timely resolution of disputes and hopefully, the establishment of good faith practices on the part of insurers which are now often lacking in the system.

We have a number of questions regarding the recommendation that claimants "*be provided with the opportunity to request an internal review by the insurer following a benefit denial".* Specifically, we wonder:

- Who would these 'internal reviewers' be? Would they be senior adjusters or health care professionals? If the latter, is the concept similar to that of Independent Examiners?

- How would the outcome of the internal review impact on the claimant's ability to further pursue the matter if the internal review supports the benefit denial?

A FRAMEWORK FOR POSSIBLE LEGISLATION [P.35]

We are fully in support of the objective of "*Ensuring access to timely and necessary treatment would be a 1st principle".* However, we are concerned about the outcomes of a system wherein the arbitrator is reliant on a paper review for those 'lower threshold' disputes. Most would agree that the subtleties and complexity of the human mind and body are not typically well reflected on paper and there is no substitute for meeting an individual in person.

While we see merit in a meeting between the claimant and insurer to resolve denied benefits, we do have some concerns with the suggested aspect of the framework that contemplates such a meeting in the absence of the treating provider. Specifically:

- Treatment recommendations are technical and based in clinical science. We doubt the ability of most claimants to properly explain treatment recommendation in an adequate manner, and the ability most insurance adjusters, who similarly lack the appropriate clinical background, to understand them. This is especially true to non-MIG injuries which are complex in nature.

- We are concerned about the ability of insurance adjusters, as lay people, to lend equal consideration to visible and invisible injuries. That is, it is generally easier for an adjuster to understand and relate to the needs of a claimant with an obvious physical injury such as an amputation. However, it is much more difficult for non-clinicians to understand the challenges of a claimant with traumatic brain injury or psychological impairment because the victims may

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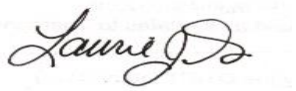
often appear “normal” and even be able to carry a conversation. Meanwhile, such victims may suffer from debilitating depression, memory, concentration, fatigue and countless other severe impairments.

We are also concerned about the ability of brain injured victims suffering from communication and/or cognitive disorders to advocate for themselves under the proposed framework. We believe that while well intentioned, the framework will result in discrimination against the most impaired population, which in fact needs rehabilitation services the most. This in turn will lead to more disputes. We believe that claimants need a certain level of support from the treatment provider making the recommendations if this recommendation was to be implemented.**In conclusion, we support many of the recommendations and welcome any opportunity for future discussion and consultation with respect to these comments.**

Sincerely,



Laurie Davis,
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