Coalition

Representing Health Professionals in Automobile Insurance Reform

July 14, 2008

Willie Handler, Senior Manager
Automobile Insurance Policy Unit
Financial Services Commission of Ontario
5160 Yonge Street, 15th Floor
Box 85
Toronto, Ontario M2N 6L9

Re: 5 Year Review of Statutory Accident Benefits Schedule

Dear Mr. Handler:

On behalf of the Coalition Representing Health Professionals in Automobile Insurance Reform, we are pleased to submit these comments and recommendations which we trust will assist in the review of the Statutory Accidents Benefits Schedule.

The coalition is strongly supportive of collaborative processes among stakeholders to improve the system for consumers, and is committed to assisting FSCO in this.

In preparation for this review, the Coalition conducted a survey of practitioners. References to this survey, which is attached as Appendix A, are made throughout this submission.

We also note the recent report of the Neck Pain Task Force of the United Nations Bone and Joint Decade which provides much significant new research in the area of neck pain. A summary of significant findings includes:

- Neck pain is common and frequently persistent or recurrent.
- There is typically no single cause and no single effective treatment for Grades 1 or 2 neck pain:

- Effective treatment options are all low risk and may provide short-term relief when provided in moderation.
- Informed patient preferences are key to treatment decisions.
- A variety of treatments may need to be tried.

- Routine imaging of Grades 1 or 2 neck pain will not increase understanding of causation.
- There is not enough evidence to support the use of invasive interventions in Grades 1 or 2 neck pain.
- Providers, policy makers and insurers need to move toward universal, validated, evidence-based treatment guidelines.

In examining the processes that support claimants' access to needed treatment it is critical to consider the variances in treatment approaches and recovery times that are associated with these conditions as demonstrated in this and other research

We have chosen to focus our comments on the following six key issues which we perceive to be the most significant SABS issues at the current time. We have addressed these with due consideration for the three areas of concern articulated by FSCO; affordability and availability, consumer protection and process.

This does not mean that the Coalition does not or will not have opinions and advice on other matters, and you are urged to consult with the Coalition on any matters of interest which are not addressed herein.

A. OCF-22 Requests for Assessments

1. Number of OCF-22 Requests for Assessment

   a. The introduction of the OCF-22 was a result of the industry's requirement that most assessments be pre-approved. Prior to this all services required approval, but not necessarily pre-approval. The OCF-22 reflects the SABS changes intended to protect insurers from uncontrolled assessment costs. This mechanism necessarily required timelines for response and potential "deemed approved" provisions to ensure timely access to services and protection of the claimant.

   b. We have heard the insurance industry concerns that there is a "deluge" of OCF-22s, which are considered to be inappropriate or unnecessary. We also understand, anecdotally from practitioners of member organizations who

conduct insurer examinations, that there are instances of multiple OCF-22s when a single form could be used and instances of multiple requests for the same assessment. In other words, the issue of the number of OCF-22s submitted is a complex one that requires more data and information to quantify or to place qualifiers such as 'inappropriate'.

c. In the practitioner survey, the following were noted:
   i. 23% of respondents reported that insurers rarely or never respond to an OCF-22 within the regulated three days. (Q14)
   ii. 17% of respondents reported that assessments proposed on an OCF-22 were denied at least 50% of the time. Conversely, this means that 85% of practitioners report that the OCF-22 is approved more than 50% of the time. (Q15).
   iii. In a related question 47% of respondents reported that 75-100% of OCF-22s sent for an insurer examination were approved by the IE assessor. (Q16)
   iv. The majority of respondents (76%) felt that the current timelines were appropriate. (Q13).

   This suggests that there is much wasted effort and costs, and delay for claimants, when OCF-22s are denied and subsequently approved by an IE assessor, and that this is a common occurrence.

2. Arbitrary nature of OCF-22 denials

   a. Claims management practices, and apparently the rate of OCF-22 denials appear to vary considerably among insurers. At times, a decision to deny seems arbitrary, a suggestion supported by the large number of subsequently approved proposals. It is possible that adjusters are sometimes placed in the situation of having insufficient knowledge, guidance, or time to thoroughly evaluate OCF-22s, and that a denial and referral to an IE is simply an expedient, safe option. It is also, unfortunately, costly for the system and therefore ultimately for consumers. Our recommendations below should help reduce the incidence of arbitrary denials.

3. Data Transparency

   a. The coalition has been and continues to be supportive of the development and introduction of Health Claims for Auto Insurance (HCAI). The universal need for accurate, comprehensive and quantifiable data on the performance of the auto insurance system remains. It is unfortunate that we are once again in the position of having limited data to inform this review process, in this case data on the use and disposition of OCF-22s. The Coalition urges FSCO to work with stakeholders to ensure the re-introduction of HCAI as soon as possible.

4. Claimant Signature Required

    a. The claimant signature on the OCF-22 is "optional" and is not intended to be "required" by an insurer, yet many insurers insist that the OCF-22 is incomplete without it. 79% of respondents to the practitioner survey indicated that insurers sometimes or always require the claimant's signature.(Q18)

    b. It is still common practice among some insurers or some adjusters to delay consideration of an OCF-22 until the claimant's signature is obtained. We understand that this practice would be considered an unfair or deceptive act or practice (UDAP). On the other hand, we acknowledge the concern by some adjusters that claimants should be fully aware of the details of any proposed assessment. Our recommendations below should help resolve this quandary.

Recommendations:

- **Consult with stakeholders on the promise of the HCAI system to mitigate issues related to timelines for insurer response to OCF-22s.**

- **Consult with stakeholders to develop a Superintendent's Guideline on the submission and handling of OCF-22s to encourage the submission of and facilitate the handling of the most appropriate OCF-22 proposals. This might address, for example:**
    - **multiple OCF-22s for the same claimant,**
    - **multidisciplinary OCF-22s,**
    - **a requirement that all OCF-22s must be copied to the claimant to ensure claimant awareness**
    - **provision for IE assessor/proposer communication, as is the case with OCF-18s**
    - **criteria for adjusters regarding denial and referral for an IE**
    - **clarification that a claimant signature is not required on an OCF-22 and/or provide for the insurer to pay any additional provider or claimants costs if a signature is required.**

It should be noted that the Coalition considered and rejected a number of other suggestions for improving the use of OCF-22s including caps on the number of OCF-22s and form changes. These assessments are necessary to determine impairments resulting from accidents, to prepare plans for treatment, and to make applications for other benefits. Therefore controls on assessments cannot be unreasonable or create de-facto denial of treatment and other benefits. Any numerical cap on assessments would be arbitrary. While a high numerical limit on assessments may provide sufficient or even excessive assessments for most claimants, a cap would necessarily discriminate against some claimants. Therefore,

the above recommendations are considered to be better options in that they have less potential negative impacts on timely and appropriate access to patient care.

B. Insurer Examination Assessors/Assessments and Rebuttals

1. The replacement of neutral assessments as the mechanism to fairly resolve accident benefit disputes between claimants and insurers with the current scheme of Insurer Examinations and Rebuttals has created a new set of difficulties.

2. The coalition is unable to assess whether or not this change has had the expected impact on cost reduction. However, we understand from member organizations that the complexity of the system and the existence of IE brokers mean that the payment to assessors is often insufficient to attract the best qualified assessors. The result is our observation that Insurer Exams are often completed by under qualified or inexperienced practitioners.

3. Member organizations report that the rebuttal reports more than occasionally result in an insurer's decision to revise their denial decision. We believe this is, in part due to the lack of expertise in some IE assessors and emphasizes the benefit to claimants of the rebuttal process.

4. It is extremely clear that if the system of Insurer rather than neutral assessments remains as the first level review of accident benefits disputes, then the provision for rebuttal assessments and reports must also remain.

Recommendation:

- **Consult with stakeholders to establish Guidelines for those performing Insurer Examinations including requirements for such things as:**
    - **Years of experience of practice in the area to be assessed**
    - **Current practice in the area to be assessed**
    - **Education, training, and ongoing professional development**

C. Pre-Approved Frameworks

1. In the practitioner survey:
    a. 47% of respondents indicated that less than 50% of their WAD patients are treated in the PAF (Q32).
    b. 46% of respondents indicated that a subsequent OCF-18 treatment plan was submitted in more than 50% of PAF cases. (Q33)

2. Speculation on whether this post-PAF treatment is or is not reasonable or required will not be productive as there is insufficient information on why this treatment is proposed, including a lack of health status information.

3. There is still confusion on the part of both providers and insurers on the applicability of the PAF and the criteria for inclusion/exclusion.

4. There is anecdotal evidence that claimants' legal advisors sometimes recommend against the use of the PAF because of the impact on other benefits – Income Replacement and Attendant Care Benefits.

5. Overall, it would appear that these factors have resulted in an under-utilization of the PAF compared to the expected utilization.

Recommendations:

- **Consult with stakeholders on removing the restriction on Income Replacement Benefits and Attendant Care Benefits for claimants who receive the PAF on the expectation that this will increase participation in the PAFs.**

- **Provide for mandatory training of insurer representatives and health care practitioners on the PAF inclusion/exclusion criteria.**

D. Collateral Benefits

1. In the practitioner survey:
   a. Only 21% of respondents agreed or strongly agreed that their experience in receiving payment from extended health insurers prior to billing an auto insurer was satisfactory. (Q8)
   b. 57% of respondents indicated that auto insurers always require documentation from the extended health care insurer, and an additional 30% responded "sometimes". (Q7)
   c. 58% of respondents indicated that more than 50% of their auto insurance claimants had extended health insurance. (Q9)

2. There were a variety of practitioner suggestions for improving the collateral benefit situation ranging from making auto insurers the first payer for MVA related injuries, to providing auto insurers with the ability to collect directly from EHC insurers.

3. This remains one of the most unsatisfactory and frustrating administrative issues for both claimants and practitioners.

Recommendation:

- **Consult with stakeholders on methods of simplifying or amending the process for indentifying and collecting collateral benefits.**

E. Accident Benefits Application Package

1. In the practitioner survey:
   a. 19% of respondents indicated that they were *always* asked, and 43% of respondents indicated that they were *sometimes* asked to help claimants compete the Accident Benefits Application Package. (Q5)

   b. 10% of respondents said assessment or treatment was *always* delayed, and 61% of respondents said that assessment or treatment was *sometimes* delayed as a result of the AB package not being completed. (Q6)

   c. 43% of respondents disagreed or strongly disagreed with the statement '*On average, my patients indicate that they are provided accurate information by their adjuster that facilitates timely access to early rehabilitation and treatment.'(Q4)*

2. Overall it appears that the AB application package and process remain overly complex and a barrier to claimants receiving accident benefits in a timely manner.

Recommendation:

- **Consult with stakeholders to simplify the AB application package and process**

F. Ongoing Forum for Stakeholder Consultation

1. The Coalition appreciates this opportunity to provide input into the 5 year review of the Statutory Accident Benefits Schedule. There are a number of significant issues identified which should be addressed. We strongly believe in the value of collaborative problem solving.

2. In the past there have been a number of effective formal mechanisms for ongoing monitoring and consideration of auto insurance issues including the Accident Benefits Advisory Committee and the Minister's DAC committee.

Recommendation:

- **Establish an ongoing forum, led by FSCO, for collaboration among stakeholders in the identification and discussion of issues of concern in the automobile insurance sector, and to provide recommendations to FSCO.**

We trust that these comments will assist FSCO. We are available to discuss this document or any other issues.

Sincerely,

Dorianne Sauvé
Coalition Co-Chair
CEO, Ontario Physiotherapy Association

Robert Haig, DC
Coalition Co-Chair
ED, Ontario Chiropractic Association

On behalf of the following members of the Coalition representing Health Professionals in Automobile Insurance Reform:

Canadian Society of Chiropractic Evaluators
Ontario Association of Social Workers
Ontario Association of Speech-Language Pathologists and Audiologists
Ontario Chiropractic Association
Ontario Massage Therapist Association
Ontario Physiotherapy Association
Ontario Psychological Association
Ontario Society of Occupational Therapists