Executive Summary

The Coalition of Health Professional Associations in Automobile Insurance Services (Coalition) represents over 10,000 front line health professionals from ten regulated health professions involved in the assessment and treatment of Ontarians after an auto accident.

Since the last major changes to the *Statutory Accident Benefits Schedule (SABS)* in 2010, the Coalition has been supportive of the implementation of new regulations and business processes to ensure that the insurance product in Ontario is affordable for all Ontarians. These changes have curtailed many of the concerns with the previous product in areas of fraud. We understand the government's need to deliver on the promise of a 15% premium reduction by August 2015, however, we are concerned that some of the recent changes proposed in the spring 2015 budget will impact access to adequate and appropriate accident benefits.

In reviewing the recommended changes being proposed, the Coalition's comments can be summarized as follows:

1. We do not support the inclusion of attendant care services under the medical and rehabilitation benefit limits or the reduction in amounts of combined benefits both for catastrophic and non-catastrophic cases
2. We are concerned by the addition of the new test of "essential" to those benefits not explicitly listed in the SABS and would recommend, should the government insist on adopting this test, that services such as massage therapy and acupuncture be explicitly added to the list of medical and rehabilitation services.

We have several recommendations regarding the changes proposed to the Catastrophic impairment definition including:

- for traumatic brain injury that injuries classed as Upper Moderate disabilities be included to qualify for catastrophic designation after one year
- allowing pain to be quantified as a separate impairment measure
- retaining the use of AMA Guides 4, chapter 14, for determination of marked or extreme impairment due to mental and behavioural disorders
- if the Global Assessment of Functioning (GAF) is adopted as a measure for impairments due to mental and behavioural disorders, establish the threshold at a GAF score of 50 rather than 40
- a list of indicia should be clearly intended to be illustrative, rather than required
- rating by analogy within Guides 4 or using the California method for combining impairments

We thank the government for the opportunity to respond to these proposed changes.

Respectfully Submitted,

Dr. Moez Rajwani, Co-Chair

Dorianne Sauvé, Co-Chair

Coalition of Health Professional Associations in Ontario Automobile Insurance Services Response to 15-MOF011 Proposed Amendments to Insurance Act Regulation 34/10 (Statutory Accident Benefits Schedule - Effective September 1, 2010)

Introduction

According to the 2009 SMARTRISK Foundation study, motor vehicle accidents (MVA's) are one of the leading causes of death, as well as both permanent and partial disability in Canada[1]. Of all unintentional injury causes, MVA's have the highest associated *indirect* social costs (i.e. costs related to reduced productivity due to hospitalization, disability and premature death) and second highest *direct* social costs (i.e. health care costs arising from injury such as hospitalization, rehabilitation and care needs) in comparison to all other causes of injury (SMARTRISK, 2009).

The most recent (2012) Ontario Road Safety Report authored by the Ontario Ministry of Transportation documents that, although Ontario roads continue rank among the safest in North America, on average, one person is killed on Ontario's roads every 15 hours and that, in 2012, 61,001 people were injured as a result of involvement in an MVA[2]. 568 people died as a result of an MVA in 2012 and 29, 922 people required hospital care. Of these, 2,590 people required admission to hospital totaling 49,731 hospital days of stay.

For the individuals who sustain serious injuries from a motor vehicle accident, a return to their pre-accident activities of normal life can be dependent upon timely access to adequate, and often specialized rehabilitation services[3]. Many victims of motor vehicle accidents (e.g. individuals with brain injuries, chronic pain, spinal cord injuries, and mental health difficulties) will require life-long rehabilitation support services, either on an ongoing basis or an intermittent basis, due to chronic cognitive, physical and emotional impairments.

Unfortunately, the public health system presently offers very little assistance to injured accident victims who require rehabilitation services. There is a recognized lack of hospital-based ambulatory and community rehabilitation services in this province (Ministry of Health and Long Term Care, 2006), and the fees of the allied health professionals that are commonly involved in the rehabilitation process are largely not covered by OHIP. Thus, the medical and rehabilitation services that are accessed through the motor vehicle insurance system are of significant importance and the legislative policy governing these services has the potential to influence the ultimate health and recovery outcomes for individuals who are injured in motor vehicle accidents.

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[1] SMARTRISK. (2009). The Economic Burden of Injury in Canada. SMARTRISK: Toronto, ON

[2] Ministry of Transportation. (2012). *Ontario road safety annual report.* Safety Policy & Education Branch. Retrieved from http://www.mto.gov.on.ca/english/publications/pdfs/ontario-road-safety-annual-report-2012.pdf

[3] Ministry of Health and Long Term Care. (2006). *Report of the Trauma Expert Panel.* Retrieved from http://www.health.gov.on.ca/english/providers/program/critical_care/docs/trauma_rep_01_20070601.pdf

Past Reforms are Achieving Significant Cost Savings

Following the 2010 reforms to the *Statutory Accident Benefits Schedule (SABS)*, a number of cost control measures have been introduced which have successfully reduced accident benefit costs and fraud in the system.

- The introduction of the Minor Injury Cap reduced available benefits for those with sprains, strains and other soft tissue injuries (estimated to be approximately 70% of all claims, according to HCDB data reports) from $50,000 to $3,500.
- Housekeeping and homemaking benefits, and the caregiver benefit were made unavailable to all but the 1% of catastrophic claimants. This resulted in enormous savings for insurance companies as they now pay neither the benefit nor the costs of insurer examinations to determine eligibility for these benefits for all non-catastrophic claimants.
- Application of a maximum assessment fee at $2000. Insurers have seen significant reductions in the numbers and costs of assessments.
- None of the benefits (including attendant care, income replacement, minor injury guideline, assessment fee, med/rehab limits, catastrophic limits) have been indexed with inflation.
- The removal of the requirement for the insurer to complete an insurer's examination.

According to the most evolved claims data from HCAI[4] (from accidents in 2011) which admittedly do not include the cost of attendant care:

- approximately 74% of accident claimants began treatment in the Minor Injury Guideline, which limits the consumer to $3500 in therapies; they cannot access the $50,000 in the med/rehab benefit.
- 23% of claimants received treatment only within the guideline and averaged $1600 per claim.
- 51% of claimants started in the MIG and received additional treatment beyond the guideline but still averaged only $3800 in treatment.

There are measures more recently put into place whereby we have yet to consider the potential cost savings such as:

- anti-fraud measures implemented over the last two years, the most recent of which, service provider licensing through FSCO, has been active for less than 6 months;
- February 1, 2014 restrictions on attendant care tied to economic loss;
- the effect of recent regulations that limit the costs of goods, deny mileage costs for health care providers who treat patients in their homes, and reduce the amount of interest paid by insurers for late and unpaid claims.

[4] Ontario Health Claims Database HCDB Standard Report 2014 – H2 Retrieved from: http://assets.ibc.ca/Documents/Auto%20Insurance/facts/HCDB-Standard-Report-2014H2.pdf

Table 1: 2011 Med Rehab Expenses from HCDB Standard Report

Average Amount Paid per Claimant by Medical and Rehabilitation Expense Class- 2011	Number of Claimants	Percent of total claimants	Insurer Paid	Percent total insurer paid	Average paid per claimant
Treatment - Subtotal	55,489	93.75%	246,789,766	51.55%	4447
Treatment - MIG only	13,466	22.80%	21,649,480	4.55%	1609
Treatment - non MIG only	12,034	20.35%	110,575,719	23.15%	9236
Treatment - MIG and non MIG	29,989	50.60%	114,564,567	23.95%	3819
Insurer initiated exam	27,216	46.05%	138,869,977	29.05%	5106
Provider initiated exam	25,451	43.00%	34,903,177	7.30%	1371
Goods and supplies	11,941	20.20%	7,622,429	1.60%	639
Missed/Canceled appointment	12,956	21.90%	17,243,878	3.60%	1328
Transportation	9,120	15.40%	24,154,215	5.05%	2656
Others	5,772	9.75%	4,234,908	0.85%	730
Unallocated Amount	0	0.00%	4,703,397	1.00%	0
Total - All Expense Classes	59,178		478,521,747		8088

What is also important, however, is to retain a fair and accessible Accident Benefit system in Ontario that allows for readily available access to rehabilitation services for those who are acutely injured. Without these services, the injured person would inevitably turn to OHIP and other publically funded health services creating greater demand on an already overburdened, under-resourced system. Additionally, many of the required rehabilitation services, such as community-based vocational, psychological, occupational therapy, massage therapy, speech language pathology and chiropractic, are not available through the publically-funded health care system.

Research provides evidence that immediate access to rehabilitation lowers the severity and prevalence of physical, mental, emotional and work disability. By virtue of an Accident Benefit system which provides immediate access to rehab and enforces that a claimant must "mitigate his/her loss" results in a reduction in the overall cost of a bodily injury (tort) claim. Without a strong and viable Accident Benefit system, there would be a cost increase, not only on the Bodily Injury side, but inside our social programs. The end result would be significant disability at a cost to every Ontario taxpayer, and a 'quality of life' cost to the individual claimant.

In reviewing cost cutting opportunities the Coalition is recommending that government examine the cost of the claims process (e.g. the cost of insurer examinations, CEO salaries, bonus structures, etc.) as these in our view have not been critically looked as a potential for reduction in medical and rehabilitation expenditures.

Changes to Med/Rehab and Attendant Care Benefits

The proposed changes to the SABS include:
• *Change the standard benefit level for medical and rehabilitation benefits to $65,000 (from $50,000) and include attendant care services under this benefit limit. An option will be provided for consumers to increase this coverage to up to $1 million;*

• *Include attendant care services with the $1 million medical and rehabilitation benefit for catastrophic impairments, and provide the option for additional coverage of $1 million, for $2 million in total coverage;*

We do not support this reduction and combination in benefits that will affect only those with serious or catastrophic injuries and impairments as this strategy effectively requires our most seriously injured patients and their caregivers to make a choice between getting the immediate personal care support they need during the acute phase of their injury, or the treatment they need to strengthen, re-mobilize, and get back to their normal activities of daily living. It is our understanding that the use and cost of attendant care has in fact been decreasing since 2010; we are therefore unclear on the rationale of government to further restrict access to this benefit.

The attendant care benefit provides support for people objectively assessed to be unable to care for themselves at a point in time. Re-assessment assures that the benefit is not inappropriately extended beyond a claimant's need.

Following the 2010 reduction in med/rehab benefits from $100,000 to $50,000, we have seen many seriously injured, but non-catastrophic claimants, run out of funds even when very well managed. There are no longer services available within the OHIP system to access, so they regress, risking the ability to return to work and productive lives. If any of these injured claimants are potentially catastrophic, there may be 2 or 3 years before this designation is applied and, in the meantime, they are waiting without any additional funding for their rehabilitation to continue.

CASE STUDY

A 13 year old girl is hit by a truck while crossing the street. She sustains numerous injuries including:

- Mild traumatic brain injury
- Multiple fractures including facial, pelvic, rib, tibia and thoracic spine
- Lung contusion, liver laceration and soft tissue injuries

Upon discharge from hospital, the girl was unable to walk, required wound care and help with her personal care, and was experiencing significant levels of pain, anxiety and post-concussion type symptoms (including headaches, sensitivity to light and noise, difficulty concentrating, etc.).

Cont'd…

The girl's rehabilitation needs included occupational therapy, physiotherapy, a rehabilitation assistant, psychological counselling, and tutoring support. Her transition to school was gradual but difficult due to the combined effect of her physical, sensory, cognitive, and psychological challenges. CCAC could only offer limited consultative rehabilitation service vs. the more intensive rehabilitation programming that was required. CCAC provided some limited, interim attendant care support (PSW services) until funding became available through automobile insurance benefits.

Despite careful and conscientious use of medical and rehabilitation benefits, funding for therapies was exhausted within 8 months. Transitional support was provided by the school who undertook to assist the family to find publicly funded resources. Three years following the accident, the girl's injuries were deemed to meet the catastrophic threshold and funding for medical and rehabilitation support has again become available. During the time between when her initial medical and rehabilitation funding was exhausted and she was deemed eligible for the enhanced catastrophic-level benefits, the girl had extremely limited rehabilitative/academic supports and regressed. Whereas her goal had been that she would attend university and enter a professional field (e.g. medicine, pharmacy, engineering, etc.) as her older siblings had done, she is now in high school and is struggling with attendance (due to anxiety) and academic performance (due to learning difficulties). Her resistant, oppositional behaviours cause significant challenges for her parents.

Had rehabilitation interventions been able to continue, her outcome and status at this stage post-accident, in all likelihood would have been more successful. Her tort case is not yet settled.

For the 1% of claimants who have catastrophic injuries, the government's proposed amendments to the SABS reduces benefit entitlement by 50%—from $1M in med/rehab and $1M in attendant care to $1M to cover **both** benefits. While some individuals may have a tort claim to cover the shortfall, not everyone can sue (e.g. single vehicle collisions) and these individuals will simply run out of funds to pay for their medications, prosthetics, wheelchairs and therapies, again turning to the public health system and social assistance for help.

Providing an optional benefit allowing consumers to purchase additional coverage may appear to be a good idea in theory, but in practice, we have seen less than 2% of insured people opt for better coverage. The insurance purchasing public is rarely informed of the availability, affordability, and the importance of optional benefits. This needs to become a focus of robust and carefully designed educational programs to be monitored by government. However, experience shows that very few consumers will purchase optional benefits and thus optional benefits are not a substitute for adequate standard level of accident benefits in every insurance policy. This is partly the result of a desire to keep their policy costs down, combined with the hopeful optimism that they will never need additional coverage. This policy direction will certainly prove problematic for individuals, like cyclists and pedestrians (7703 of whom were involved in collisions in 2012, according to the Ontario Road Safety Report 2012), who are covered under someone else's policy, as they are restricted to the limits of coverage that someone other than themselves chose to make.

Requiring goods and services not explicitly listed in the Statutory Accident Benefits Schedule to be "essential" and agreed upon by the insurer

The proposal to change the entitlement test for goods and services not explicitly listed in the *Statutory Accident Benefits Schedule (SABS)* from "reasonable and necessary" to "essential" raises a number of critical issues.

Explicitly listed

The goods and services presently explicitly listed in the SABS do not constitute the breadth of options that the public and their health care professionals have found to be efficacious for the treatment of motor vehicle injuries. Unlike the Alberta legislation from which this proposal is likely recommended, the SABS does not explicitly list massage therapy and acupuncture, for example.

In fact, the list of interventions that are routinely used to achieve measurable positive outcomes are not constrained purely to those currently listed under the SABS, but include such examples as:

- Massage therapy – often included on plans from chiropractors and physiotherapists
- Kinesiology services – also often included with chiropractic and physiotherapy plans
- Acupuncture – often provided under other discipline names
- Traditional Chinese medicine
- Dietary goods and services

The list of goods and services currently listed in the SABS needs be revised and updated to reflect current best practices in health care, not just a profit/loss ledger that is in dispute within the MVA related health care field.

Test of Essential

Implementation of this proposed policy direction will require anyone who is proposing goods or other non-listed services to demonstrate that the service is “essential” and, if the insurer does not agree, it will presumably not be funded. “Essential” is a term that has a meaning considerably more difficult to demonstrate that the “reasonable and necessary” test. “Essential” is commonly defined as “absolutely necessary; extremely important”. Arguably, all the services listed in the SABS should be subject to the same test, so there is an implicit assumption that the services not explicitly listed in the SABS require a much higher threshold test. In addition, the same service may be subjected to a different threshold depending on the provider delivering the service. For example, a physiotherapist may provide massage or acupuncture as part of their physiotherapy-based rehabilitation and would be required to meet the threshold of “reasonable and necessary”, while the same service provided by a massage therapist or an acupuncturist would require them to meet the “essential” threshold under this new amendment.

Currently, the determination of an "essential" service is not defined in legislation. The word "essential" does have a history of use in automobile insurance claims legislation within Canada, particularly in the province of Alberta for use in the Alberta Standard Automobile Policy. Alberta has defined the term so that the outcomes may be defensible from the perspective of an ethical health care provision.

"*In addition, for other services and supplies that are, in the opinion of the insured persons attending physician and is the opinion of the insurer's medical advisor, essential for the treatment or rehabilitation of the injured person." Alberta Standard Automobile Policy, Section B – Accident Benefits, Subsection 1 – Medical Payments, (1) (b)*

It is not, therefore, at the discretion of the individual adjuster but includes opinions of an attending physician of the insured and a medical advisor of the insurer. The inclusion of these medical experts allows for the proper determination of necessary medical services or goods.

By not including medical experts in the judgement of the services or goods as necessary, the Government of Ontario reduces the defensibility of the insurer's decisions. The potential denial of services or goods as non-essential purely for reason of cost will lay the burden on the public healthcare system, a system that is already overburdened. In our opinion this raises unacceptable barriers to care for the people of Ontario. We would further assert that, as the determination of what is "essential" is a new test that has yet to be tested and defined in the court system, there will inevitably be significant delays in accessing treatment while we wait for case law to determine the definition.

The implementation of these changes will create barriers to care for a variety of specific services utilized by the MVA- injured population. While this may be seen as an attempt to rein in cost, there is no research to justify this strategy. We believe that true cost savings can only be achieved when MVA claimants receive appropriate care, for the appropriate time, and at the appropriate level, enabling them to achieve their rehabilitation potential and to resume their pre-accident roles which may include meaningful, gainful employment and reduced reliance on long-term benefit supports.

The Coalition does not support the addition of the new test of "essential" for goods and services not explicitly listed in the SABS, and requests that, should the government wish to be more stringent in determining acceptable goods and services covered under the SABS, that additional services such as massage therapy and acupuncture be added to the list of services in Section 15 to reflect current best practices in health care.

Changes to Catastrophic Determination

In August of 2012, the Coalition had the opportunity to respond to the report completed by the Superintendent on the definition of catastrophic determination, dated December 15, 2011. We believe our recommendations continue to be important for consideration and outline them again below.

Paraplegia or Tetraplegia

We acknowledge the modifications provided by the Superintendent in the classification of the ASIA in patient spinal cord rehabilitation not necessarily being required to be delivered in a public rehabilitation hospital. Our member associations do have some concerns that the permanent ASIA Grade is/or will be D provided that the insured has a permanent inability to walk independently as defined by scores 0-5 on the spinal cord independent measure, Item 12.

The described level of ambulatory mobility may require revision. Some individuals, who demonstrate indoor mobility of ten meters, may in fact have a catastrophic impairment.

Severe Impairment of Ambulatory Mobility

We support the Superintendent's comment in this area, which acknowledges and recommends the stakeholder position that completion of an in-patient rehabilitation program is not necessary.

Blindness

We support the recommendation to update the definition by adding reference to 20/200 visual acuity threshold.

Traumatic Brain Injury in Adults

Member organizations have identified concerns in this area to indicate that injuries classed as Upper Moderate disabilities be included to qualify for catastrophic designation after one year.

Pain

The Coalition does not support the Superintendent's recommendations to accept the expert panel's recommendation that the catastrophic definition should not allow pain to be quantified as a separate impairment.

Conditions such as chronic pain, Fibromyalgia, complex regional pain syndrome and other pain-related disorders have significant impact on the quality of life of individuals. The scientific understanding of the neurophysiology of pain conditions is evolving and impacting clinical measurement and there should be no arbitrary exclusion of these important and functionally significant conditions. In order to be rated a condition it must be diagnosed using a current standard, causation must be demonstrated, and there must be a determination of the most analogous condition. What may seem initially to be an uncomplicated injury, may become severely impacted by the individual's pain; disorders evolve over time. The quantification of pain in the AMA Guides is minimal however, excluding a significant component of the patient's health status. The physical ratings in the Guides 4 take into account the pain that is generally associated with the physical impairment. Additional rating should be provided for those individuals whose pain experience is beyond that generally captured in the physical impairment rating.

Mental and behavioural definition

The government's proposed changes introduce serious inequity and discrimination against accident victims with impairments due to mental and behavioural disorders (including brain injuries).

We agree with the government's proposal to retain the use of the term mental and behavioural for impairments due to mental and behavioural disorders rather than using the term 'psychiatric'.

We strongly recommend retaining the use of AMA Guides 4, chapter 14, for determination of marked or extreme impairment due to mental and behavioural disorders. If the Global Assessment of Functioning (GAF) is adopted as a measure for impairments due to mental and behavioural disorders, it is vital that the government establish the threshold at a GAF score of 50. Establishing a threshold at a GAF score of 40 as recommended by the Superintendent is discriminatory and inequitable; it requires a much higher threshold than for impairments due to physical disorders and unfairly disadvantages accident victims with impairments due to mental disorders. A GAF score of 40 is the equivalent of quadriplegia and an individual whose impairments preclude useful functioning. Definitions for other physical impairments are more consistent with impeding but not precluding useful functioning, which is consistent with a GAF threshold of 50.

The indicia as described by the expert panel are the equivalent to an individual whose impairments preclude useful functioning, e.g. quadriplegia. Definitions for other physical impairments are more consistent with impeding but not precluding useful functioning. If a list of indicia is to be included in the definition it must be consistent with a threshold of a GAF score of 50 to avoid discrimination, however, given the number of factors that influence utilization of and access to health care, a list of indicia should be clearly intended to be illustrative, rather than required.

We do not support a limited list of specific mental and behavioural diagnoses that may be considered for catastrophic impairment determination. The use of a limited list that includes only a subset of mental and behavioural disorders is unscientific and discriminatory. It is also unnecessary as any diagnosed disorder must be shown to be a result of an MVA, and any mental and behavioural impairment must be due to that disorder.

In order to provide more equitable access for accident victims with impairments due to mental and behavioural disorders, we suggest including psychologists with appropriate expertise to conduct catastrophic impairment examinations and complete applications.

<u>Regarding combining impairments</u>
The Coalition supports combining impairments, however, use of Guides 6, as proposed by the government, introduces inequity and discrimination. Rating by analogy within Guides 4 or using the California method are alternatives that are fairer and more equitable.

The Coalition looks forward to working with government to ensure that future amendments to the Statutory Accident Benefits Schedule allow for an insurance product in Ontario that is affordable to all Ontarians, without severely impacting access to adequate and appropriate accident benefits.

Respectfully Submitted,

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