The Coalition of Health Professional Associations in Ontario Automobile Insurance Services (the "Coalition") is pleased to have the opportunity to provide a submission to the Ministry of Finance regarding "Care not Cash" default for Accident Benefits (ABs) for injured individuals with non-catastrophic injuries (CAT).

The Coalition represents over 40,000 regulated, front line regulated health professionals from nine professions involved in the assessment and treatment of Ontarians. The health professions we represent are key stakeholders in the auto insurance system and advocate for timely access to assessment and care for claimants.

The government's statements regarding the proposed "Care not Cash" default highlight the importance of improving the claims experience and increasing access to timely care. However, some parties have focussed more narrowly on the removal of cash settlements.

We agree that it is important to focus on improving timely access to care and to reduce the proportion of Accident Benefit (AB) funds that are spent on cash settlements. However, simply removing cash settlements will not improve access to care. If restrictions on cash settlements are brought in, it is essential that simultaneous changes are made to provide consumer protection and access to accident benefit funding for care. Without simultaneous implementation of solutions to improve the claims experience and access to care, removal of cash settlements will in fact reduce rather than increase access to care.

The Coalition's responses to the consultation questions posed are provided below.

Current State: Cash Settlements

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

<u>Denial of care is the main reason for seeking cash settlements</u>

Insurer denial of funding for care is the main reason injured persons seek cash settlements. Most injured individuals begin the claims process seeking care and recovery of health and function, not looking for a cash settlement. This is consistent with health research that timely care produces better and more cost effective rehabilitation outcomes.

For insured individuals, the denial of a claim can be devastating. They have little control over a situation that directly affects their quality of life. It is our experience that insured individuals seek legal counsel and cash settlements when they become frustrated with their claims experience.

Those who have a good claims experience are generally satisfied with the services they receive through ABs, do not engage legal counsel, and do not seek a cash settlement of their ABs. In contrast, if an injured person has repeated experiences that they perceive as unreasonable denials of care and/or challenges to their integrity, they often describe being "forced" to seek legal counsel and settlement.

Flexibility needed for the provision of care

In addition, there are some instances when the insurer and the insured person jointly determine that providing a cash settlement is more consistent with the injured person's cost-effective and efficient rehabilitation plan if the injured person assumes control and responsibility for the management of their rehabilitation funding. These settlements provide the insured person with more flexibility while reducing transaction costs for the insurer. Additionally, for insured persons who do not live in Ontario or who are moving out of the province, having a cash settlement allows them to purchase the care they need in their jurisdiction.

2. If you are responding on behalf of industry, over the last ten years, what is the average:
   a) value of cash settlements by injury type?
   b) amount spent per settlement on non-medical care? (e.g., legal expenses, wage loss, independent examinations)

As non-industry respondents, the Coalition is not providing a response to the consultation question.

We would like to note that it would be useful for all stakeholders to have access to this data for the industry as well as on specific insurance companies. This would enhance transparency and support informed decision-making for consumers.

Implementation Details: Care, not Cash Default

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)?

A. Preventing Disputes and Improving Access to Care

Below we provide a number of solutions that would facilitate the early resolution of disputes. We'd like to note that a large proportion of disputes, especially those that occur early in the claim, could be avoided.

Reducing treatment denials, allowing provision of care, and avoiding disputes (which lead to pressures for cash settlements) would ensure that a greater proportion of the funds are spent on timely care rather than on cash settlements.

The following would avoid and/or reduce disputes:

(1) Allow a phase of initial care, without dispute, when there is a claim accepted

Disputes could be prevented by allowing all injured individuals, with accepted claims, to access initial care without the requirement of insurer prior approval, dispute, or Insurer Examination (IE). This would avoid up-front disputes regarding the Minor Injury Guideline (MIG) vs non MIG benefit entitlement status and initial care.

A phase of care that had "presumed approval" would allow care to commence ASAP. The time frame and dollar amount would need to be determined. Requiring that the costs and duration of the initial care be limited to a specified amount and time frame would provide cost control. Additional controls are provided by limiting these services to those provided by health professionals licensed by FSRA. Requiring compliance with fee schedules and any relevant guidelines would provide additional cost control.

Having a "no-dispute" period that allowed for initial care to be provided is essential to ensuring access to rehabilitation services as soon as possible. We know that accessing rehabilitation care sooner improves patient outcomes. Delays in care provision due to assessment delays, disputes or Insurer Examination (IE) have real consequences for the injured person through lost recovery time, loss of income and decreased quality of life.

(2) Improve insurer adjudication practices

At this time, many insurers appear to have a mindset of limiting medical and rehabilitation costs, with a default response to deny applications for care outside of the Minor Injury Guideline (MIG). The reason provided for denial most often is only that the care is "not reasonable and necessary". Some insurers even create an expectation to meet an additional test and require "compelling evidence that proposed care is essential" when this is not the test for the proposed services.

It is in keeping with the government's commitment to providing timely access to care that the role of the insurer should be to facilitate this by reasonably approving applications for treatment. While it is not the role of the insurer to direct care, they should reasonably consider applications submitted on behalf of their customers by the treating health professional.

There are a number of solutions which can be implemented to improve adjudication practices and reduce denials. A joint health professional/insurer/FSRA working group may collaborate to develop:

- *Improved OCF 18 application*

  A health professional/ insurer working group can improve the current assessment and treatment application form (OCF 18) to provide adjusters relevant information for claims adjudication.

  This working group can also develop adjudication Guidelines and training materials and programs to improve the adjudication process.

- *Adjuster Training*

  Denying a claim has real impact on the injured person's life. Any delays to accessing rehabilitation care will impact their ability to recover, and there is often loss of income and reduced quality of life while waiting for a decision on their claim. Adjusters who receive regular training to ensure their skills are up-to-date will facilitate the resolution of claims and reduce the likelihood of disputes.

  Training may include current information regarding: common types of injuries; resulting disorders; usual treatments; and range of generally expected outcomes.

- *Adjudication Guidelines*

  Adjudication Guidelines can include processes for review of treatment applications including: expectation for contact with the health professional proposing treatment and claimant when there are questions regarding the treatment plan; greater use of internal health professional consultants or other internal company experts; and triggers (flags) for denial and referral to an IE including specific questions.

  Adjudication Guidelines should also provide details regarding the specific "other reasons" for denial of a treatment plan, for example the benefit limit has been exhausted. If the denial is not based on one of these specific "other" reasons, but is based on a medical reason, the insurer should not be allowed to make this determination. When there is contemplation of a medical reason for a denial, an IE should be required.

B. Improvements of the Independent Examiner (IE) system to foster earlier resolution of disputes regarding care

In those instances where an IE is required there are a number of improvements that can readily be made to the IE system. These will improve the system's credibility and increase the likelihood that the IE opinion will be accepted. These improvements will also address some problematic outlier behaviour.

These improvements include:

- *Standards of Assessor Qualifications*

  Assessor qualifications include requirements such as minimum standards for education, training, and relevant clinical practice. Further review of the potential for a FSRA roster of "rostered"/ FSRA licensed assessors is required before this happens to determine the best approach to monitoring.

- *Assessment Guidelines*

  Assessment Guidelines may include: expectation for communication with the proposing treating health professional; use of health professional peer assessors for treatment plans; guidance regarding when to rely on paper reviews; requirement of an integrative summary in multi-disciplinary assessments; assessor review and sign off on reports.

- *Standardized Forms*

  Standardized forms may include: referral forms with pick lists of frequent questions; consent forms; practice summary and "what to expect letter" describing the IE process; report summary templates.

- *FSRA Monitoring and Compliance Enforcement*

  FSRA would provide a mechanism to monitor and enforce compliance with Guidelines and Standards. Non-compliance can be addressed through education, penalties and ultimately removal of the ability to provide IEs.

C. Improved, fast-tracked, dispute resolution for plans of care

Delays in accessing care happen when the insurer and the IE differ in opinion. Dispute resolution in these cases takes longer. When the results of the IE are not accepted by one or both of the parties and the dispute continues, an accessible, efficient, cost-effective, fast-tracked process would address the goal of resolving disputes earlier. This is required so that timely care can be provided.

A dispute resolution process outside of the License Appeal Tribunal is an option. Various options have been raised for alternative dispute resolution process (e.g. a panel of three relevant health experts). These alternatives require further multi-stakeholder exploration and development. The caution however is not to create additional administrative burdens which prolong the decision-making process.

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.

A. Exceptions to restrictions on cash settlements:

- Payment of incurred treatment costs

  Cash settlements have provided a "safety valve" for some accident victims who have encountered unreasonable denials of treatment applications. The cash settlement has provided funding for incurred costs of treatment, including debt incurred, in order for them to obtain timely treatment.

  It is not possible for a consumer to know if they will encounter a situation where an insurer denies their care when purchasing their insurance policy. A lack of information on industry data related to denial rates ensures that consumers are unable to make an informed decision.

Therefore, it is recommended that if an injured person encounters denial of their treatment plan(s) and can demonstrate that they have incurred costs for treatment expenses, they are able to enter into a cash settlement to pay these costs.

- Payment to bring a caregiver from a distance

The example provided by the government is that the injured person moves out of the country. A parallel situation would be if an injured person was going to bring a person from a distance to provide them care and needed to pay their relocation expenses.

- Living or Moving out of Ontario

In the consultation paper, one of the exceptions noted was for people who live outside of Ontario. For these people, having access to a cash settlement supports their ability to purchase care in their home jurisdiction. We would add, that this option should also be available for people who move from Ontario to another jurisdiction as they would have the same requirement to purchase care outside of Ontario.

- Children and injured persons where there is a substitute health care decision maker appointed

It is recommended that accident benefits for children be allowed to be settled to allow parents most flexibility and control in making care decisions for their children. Similarly, this flexibility should be provided in any situation in which there is a health care decision maker appointed for the injured person.

- Situations requiring longer term care:

Situations where care will be required for a number of years should be made a further exception. In these instances it is often most efficient and effective to agree to a settlement in order that the funds be available for care rather than incurring the ongoing costs associated with care applications. This would also reduce the insurer's ongoing transaction costs of maintaining an open file. An option is a time period of greater than one year (number of years to be determined) when settlement would be allowed if mutually agreed upon by the claimant and insurer.

- Injured persons with Catastrophic Impairments

If an insured person is catastrophically injured, it is recommended that a cash settlement be allowed, if mutually agreed upon by the insurer and insured person, when there has been a Catastrophic Impairment application (OCF 19) submitted. A process of how to deal with cash settlements in situations where the insurer denies the application needs to be discussed with a proper guideline put in place to avoid unnecessary costs and delays.

B. Accident Benefits are first party benefits intended to provide funding for care

As noted above, Accident Benefits are intended to be a first party system and to provide funding for timely access to treatment and rehabilitation. This is consistent with the government's focus on timely provision of care rather than later cash settlements. As noted above, it is generally when the system fails to provide funding for treatment that the insured person seeks a cash settlement.

At this time, other than for MIG care, the insurer has the authority to deny applications for care provided by the injured person's treatment providers. At times these denials may be, or appear to be, arbitrary and unreasonable. The insurer is not obligated to secure an IE on the decision to deny an application. Unless the treatment is approved by the insurer or in dispute resolution, there is no funding for treatment provided by the insurer. All invoices for services must be linked to a treatment plan approval number. Without this number, the invoice cannot be submitted to the insurer for the services.

Dispute resolution is a complex legal proceeding and generally requires involvement of a legal advisor and most often takes an extended period of time. Without the right to a cash settlement, the insured person cannot pay for legal advice during the dispute process. In contrast, the insurer has extensive access to knowledgeable adjusters, legal advice and documents. Thus in a system with no cash settlement, the ability of the injured person to effectively participate in dispute resolution will become highly restricted.

C. Reinstate "Pay pending dispute"

If a restriction on cash settlements is adopted as the default, there is a need to return to a "pay pending dispute" system which previously existed. "Pay pending dispute" would create a default to provide funding for care. Cost control under pay pending dispute is provided by limiting the insurer's obligation to payments that is found to be reasonable and necessary; limiting payable services to health professionals who are licensed by FSRA and who provide services in accord with relevant fee schedule and guidelines. In this way, "pay pending dispute" would continue to provide the insurer the opportunity to dispute payment of treatment applications that are not reasonable or necessary. However the costs of care would be presumed to be paid during dispute, facilitating timely access to care.

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)?

If a change to "Care not Cash" as the default policy option is made, the time needed for transition would be connected to auto insurance policy renewal dates. Any policy renewals after the date at which this change becomes law would be provided the new options. Education would be needed so that consumers understand the changes, their options and what a non-CAT settlement can be versus what a CAT settlement could be. It is at the time of renewal when people really pay attention to the issues regarding their auto-insurance.

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.

A. Risk of unintended negative consequence of incentivizing more insurer denials of care

We are concerned that restriction of the ability to have a cash settlement will have the unintended consequence of making some insurers even more likely to routinely deny applications for care. Removal of cash settlement may remove an incentive to approve reasonable and necessary care for some insurers. This will create more delays and provide a barrier to accessing care.

The insurer is not obligated to obtain an IE and many injured individuals are unable to manage the procedural requirements of the License Appeal Tribunal (LAT) dispute resolution process. For some insurers this might lead to even more denials as the insured person will have less recourse to challenge this position of denial of care by the insurer. Thus, rather than resulting in Care Not Cash, the injured person may have less care and will receive neither care nor cash to self-pay for care.

B. Reduced Ability to Access Legal Advocacy

Having "Care not Cash" as the default reduces the involvement of lawyers and therefore reduces the legal advocacy available to injured people. Under this default, insurance companies would control who gets benefits within a reduced 'check and balance' system due to a reduction in funds available for lawyers. There are also considerations related to accessing legal representation for disadvantaged people who have limited ability to pay for legal fees.

C. Disruption of current practice of received care based on anticipation of payment at settlement

For health professionals, there is an ethical struggle when determining to provide care to a person who cannot pay. Due to their commitment to ease suffering, some health professionals have provided timely care on a delayed payment arrangement, anticipating that they will be paid at settlement for services provided. If cash settlements are precluded this practice will no longer be possible.

Implementation Details: Optional Benefit (cash settlements)

7. What terms, conditions, limits, or other factors should the government consider in designing a cash settlement optional benefit?

A. Lack of uptake of "optional benefits"

It is our understanding that very few customers "buy up" any optional benefits. The public generally assumes that what is provided in the "standard" package should be "good enough" and that buy up options are luxuries. At the time of purchase there is little information available about what care may be required if one is injured in an motor vehicle accident, what will be the costs of care, and what the claims experience will be. The information that is most readily available is limited to cost of premiums to purchase insurance. It is price information that tends to be determinative.

If there is little uptake of "optional benefits" related to cash settlements, will there be sufficient funds to pay out cash settlements for those who do elect to purchase this option?

B. Particular challenge regarding buy up of optional benefit of a cash settlement

It is particularly confusing when trying to contemplate the value of the option to buy up for the ability to have a cash settlement.

As described in the government's consultation paper, "A cash settlement is a final agreement between an insurer and an insured person for a lump sum payment to cover the cost of past, present and future accident benefits for which the person would otherwise be eligible". As a customer it is hard to understand why it is necessary to pay additional costs for something for which "I was otherwise eligible".

The cash settlement option, is most usually sought when the claimant believes that the insurer is not fulfilling their obligations, in good faith, to provide them with the accident benefits to which they are eligible. The customer purchasing auto insurance needs to believe that their auto insurer will, in fact, provide them with the benefits to which they are entitled. Therefore, they would have little to no reason to purchase this optional benefit to obtain a cash settlement.

The language used – "cash settlement option" – has the potential to confuse consumers into thinking that by purchasing this option, they will surely receive a cash settlement in the event of an injury. There are many considerations that may affect the outcome of a claim, and in our experience there is a risk that consumers will not fully understand the considerations that may impact a future claim.

Supporting Implementation: Consumer Education and Awareness

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?

In order for customers to make informed decisions, there is a need for accurate information about the claims experience. For example, for accident victims who require treatment services beyond the initial pre-approved MIG services, what percentage face initial insurer denials even if later approved by an IE or dispute resolution? At this time, to our knowledge, such information is not available to consider when purchasing insurance.

We suggest providing a clear method of walking the consumer through the process of finding insurance, understanding terms, assessing potential need and navigating the claims process so that they are able to make an informed choice about their auto insurance policy. Having aggregate data on the industry and specific insurance company's claims payouts would support the ability of consumers to choose and puts drivers first.

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

We have observed that there have been many changes to the auto insurance system that have introduced layers of complexity. It is difficult for consumers to be aware of the impact of these changes without a clear explanation from government and industry. The use of plain language paired with visual graphics will assist in ensuring consumers are aware and able to understand the changes being made.

Additional Comments

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

<u>Comparisons to the WSIB</u>

Much of the discussion regarding "Care not Cash" has been based on the incorrect assumption that the mechanisms employed in the WSIB are readily transferrable to the auto insurance context. It has been suggested that since the WSIB does not provide for cash settlements in lieu of care, auto insurance should also disallow cash settlements of ABs for injured insured persons with non-CAT impairments.

However, the WSIB is a very different model. Employers, directly or through their premiums, are highly motivated to provide care to enable the injured worker to return to employment. The costs of care are treated as an investment which reduces the costs of paying wages to the injured worker and replacement worker. There is also no monetary cap on the amount of care or the number of years of care in the WSIB. Importantly, the WSIB case managers, nurse case managers, and return to work specialists, generally see their role as facilitating access to care including when workers have returned to work and after leaving work on a WSIB pension.

Ensuring Care is provided

The current system has other issues that need to be addressed before the cash settlement option is removed for the majority of policy-holders. We need to understand what assurances the government will make to ensure that care is provided, and that there are not unreasonable delays in accessing care for people who are injured in a motor vehicle accident.

The Coalition is aware that the current system is not functioning well enough to proceed with removing the option of cash settlements. The adversarial nature of the existing process needs to be addressed first.

Conclusion and Recommendation:

We agree that the focus of the ABs should be to provide funding for timely access to care.

If the auto insurers modify their claims processes to more frequently approve reasonable and necessary care, fewer injured individuals will seek cash settlements.

A claims review process which respects the role of the patient and treating health professional responsible for determining reasonable and necessary care, would reduce the pressure for cash settlements. Such a shift in claims adjudication, to demonstrate fair adjudication of OCF-18 applications for care, would achieve the goal of “care not cash” without removing the consumer protection provided by a cash settlement. When the system fails to provide reasonable and necessary care to the individual injured person, a cash settlement may be the only consumer protection mechanism available to allow the injured person to receive funding for the care they require.

We thank the government for the opportunity to comment on the proposed care not cash default. We would be happy to work with government on the details of our recommendations and look forward to hearing from you on how we can ensure claimants receive timely access to care.

Sincerely,

Dr. Moez Rajwani and Dorianne Sauvé, Coalition Co-Chairs