



Need for balance between cost controls and accident benefits

Key issues in 2009 auto insurance review:

✚ *Level of benefits and barriers to access:*

According to the IBC, rapidly rising accident benefit costs will require significant premium increases. The IBC has argued that to control premiums significant change is required in the auto insurance product. In the past auto insurance premiums were reduced by bringing in utilization controls, such as requiring prior approval of assessments, restricting access to income replacement for accident victims who received treatment of WAD I and WAD II injuries in the Pre Approved Framework (PAF), and by significantly reducing (30-50%) fees of health professionals. More recently, there have been some slight increases in insurance premiums.

While some further changes may be required at this time, sufficient accident benefits must be retained for the restoration of health of those who are injured and to prevent off-set of burden of care and costs to OHIP and other public systems. The proposed reduction in accident benefits (from \$100,000 to \$25,000- and to include assessments within this reduced amount) and the new barriers to access (for example, requiring a physician referral for assessment and treatment) will jeopardize the recovery of accident victims and shift burdens to already taxed public health systems.

✚ *Insurance must provide for those with higher as well as more usual needs:*

The FSCO report states, “*the insurance industry has proposed that a reduced cap of \$25,000 would adequately meet the needs of many consumers*”. \$25,000 does meet the needs of many consumers. However, a fundamental purpose of insurance is to pool risk in order to also protect the smaller group with higher needs. There is a subset of accident victims (including, for example, accident victims with multiple orthopedic injuries, single limb amputations, brain injuries requiring residential behavioural treatment programs, as well as accident victims with poor recovery, complications and/or continuing impairments from injuries that are initially diagnosed as soft tissue injuries) who, as a result of their injuries, will require goods and services in excess of \$25,000. Some accident victims in this group will not satisfy the catastrophic impairment criteria and there may not be an at-fault driver to sue. In addition, effective treatment and rehabilitation may require goods and services in excess of \$25,000 prior to the time when a catastrophic impairment determination can be made, or when a payment from an at fault driver is possible.

The IBC comparisons to AB costs in other provinces may be misleading due to low caps on soft tissue injuries irrespective of need. Contrary to IBC assertions, we cannot compare outcomes because there is no data. Outcome is not measured. What is reported as “outcome”, is actually claims closure. Claims close earlier in other provinces because available funds are exhausted. Further, in Alberta, the benefit limit is approximately \$50,000, not \$25,000 as proposed in Ontario.

✚IBC's suggestion that a higher level of benefits would be available for those with "serious" injuries is not substantiated:

The IBC submission to FSCO suggested that those who were admitted to hospital for two days at the time of the mva might have access to \$100,000 in benefits. This suggestion did not appear in the FSCO recommendations. We note that there is no data to support that two days of hospitalization is a valid predictor of those who will need a higher level of benefits. However, the decision to hospitalize may be influenced by many factors such as local bed availability and outbreaks of various hospital born illnesses. In the media the IBC has stated that it has made additional proposals for defining serious injuries. However, the IBC has not shared the specifics. Experience with catastrophic impairment determination indicates that even the most apparently straightforward criteria, such as a "GCS score of 9 or less", is controversial. Adding a definition of "serious" impairment would inevitably lead to a need to determine who was and was not included within this group, thus increasing assessments and other transaction costs. This is contrary to the policy goals to reduce complexity and assessment costs.

✚Optional benefits do not compensate for inadequate general level:

Optional benefits are suggested to address the need for a higher level of benefits. The FSCO report states, "*Consumers that feel they need a higher level of coverage could be provided the option of purchasing \$100,000 in medical and rehabilitation benefits to cover non-catastrophic injuries*". There are many who do not have the option to purchase the higher level (for example, pedestrians, cyclists, who do not purchase insurance) who would be harmed if they were injured and had higher needs. In addition, a lower general level would result in lack of services and compromise rehabilitation, as well as shifting of burden and cost of care to OHIP and other public systems.

Discussion of some proposed solutions:

✚Reduction of Complexity

- Some recommendations would simplify the system and should reduce unnecessary transaction costs while still retaining the principle of providing sufficient funding for benefits for the restoration of health of accident victims. Some examples include:
 - Allowing insurers discretion to deny applications without an Insurer Examination;
 - Increasing the time lines for insurer review of assessment applications; and
 - Simplifying forms.

✚Overall Benefit Level

- The general benefit level of \$100,000 has been in effect since 1996 and, therefore, in real terms, has already been significantly reduced over time in the context of inflation in health care costs.
- If assessments initiated by the accident victim's treatment providers are included in the \$100,000, this is a de-facto significant reduction in the benefit level.
- Auto insurers' obligation to pay costs for goods and services continue to be secondary to coverage provided by other insurers, such as extended health benefits.
 - Reduction in the general benefit level would not change the obligation to first access the other payer, it would only mean there was less coverage available from the auto insurer after the other insurance was used up.

✚Physician referral requirement

- There is a proposal to require a physician referral (usually the family doctor) for assessment applications and treatment proposals to provide coordination and utilization control.

- Requirement of physician referrals would create delays and unnecessary costs in the system. This would be especially problematic for those who do not have a family physician.
- Referral requirements are contrary to more recent directions in health policy that reinforces direct access as the most efficient and cost effective model.
- Requirement of physician referral would create an additional and unnecessary burden on already over taxed physician resources

Costs of assessments

- We agree that it is important to look at cost of examinations as a source of cost increases. From the limited data available for our review, a major cost driver is excessive utilization of Insurer Examinations (IE). Increased insurer discretion to deny applications without an IE should help to reduce the number of IE's.
- Although the media debate has become highly focused on total costs of all assessments; the most rapid growth has been in insurer- generated assessments. Contrary to what is stated by the IBC, 60% of med/rehab is not spent on assessments. It must be noted that the "assessment" costs are also applicable to all AB costs, including such costs as income replacement.
- According to the data that we have reviewed, clinical assessment to diagnose impairments and propose treatment costs approximately 10-15% of total treatment and rehabilitation costs.
- Patients frequently have more money spent resisting their requests for services than the costs of the services they ever receive. Multiple teams of insurer examiners are used to assess housekeeping needs, disability, and treatment plans put forth by the insured's chosen providers.
- FSCO Recommendations to reduce the excessive numbers of IE's include:
 - Increased time lines (increased time for review of assessment applications to 10 days parallel to treatment plans); and
 - Increased insurer discretion to deny applications without requiring an IE
- Limiting assessments to complete forms to \$200 and capping all other assessments at \$2000, including assessments for neuropsychological impairments and catastrophic impairment assessments, will interfere with provision of thorough, cost effective assessments to diagnose impairments, apply for treatment and other benefits. Reasonably required assessment costs can be more appropriately limited to professional guidelines for time required and hourly fees.
- Removal of rebuttal examinations will reduce the balance provided to the accident victim to determine if they have a basis to contest the insurer's denial of their benefits.

Expansion of the PAF

- The FSCO report recommended, *"In partnership with key stakeholders, FSCO should contact members of the Neck Pain Task Force to examine the feasibility of expanding the PAF Guidelines to provide a more extensive continuum of care and to include the treatment and assessment of other soft tissue injuries"*.
- We recommend that as a component of this review it will be helpful to consider ways to increase appropriate utilization of the Pre-Approved Framework for initial treatment and address any barriers to utilization.
- IBC proposed that PAF be expanded to include all soft tissue injuries, as well as "pain and psychological manifestations". They also proposed that the PAF be changed from an administrative mechanism to facilitate access to initial treatment, to a hard cap on all treatment and other benefits.
 - It is clinically unsound and scientifically inappropriate to utilize an initial decision to provide treatment according to the PAF to cap accident benefits for an individual accident victim.
 - It is often clinically reasonable to treat a patient based on their presenting symptoms without doing extensive tests and to presume that they will have a good recovery with modest interventions according to the PAF.

- It is known that a subset of these patients will, in fact, not have good recovery, will suffer complications, and/or will have other more subtle injuries that are not diagnosed at the time of the initial treatment decisions.
- This subset of patients will require other and/or subsequent goods and services, and it is not reasonable to cap their access based on this initial treatment decision.

✚Catastrophic Impairment Definition and Process

- The FSCO report recommends, “ *Further consultation with experts in the field is needed to amend the definition of “catastrophic impairment.” The goal for this review should be to ensure that the most seriously injured accident victims are treated fairly*”.
- The catastrophic impairment criteria have been interpreted by the courts and arbitrators to allow psychological impairments to be combined with other bodily impairments to determine the whole person impairment (WPI). However, the IBC has advocated to reinforce discrimination and unfairness against those with psychological impairments and brain injuries and to remove the ability to include these impairments in the WPI.
- Processes to allow the accident victim to access comprehensive assessment by their own selected assessors, as well as assessment by insurer- selected assessors, will need to be determined.

Ontario Psychological Association Recommendations:

- ✚ Retain the \$100,000 general benefit level.
- ✚ Retain direct access to health professionals for assessment proposals and treatment plans.
- ✚ Do not impose a requirement of physician referral.
- ✚ Reduce the excessive numbers of IE’s by providing increased time lines for insurer review of assessment applications and increased insurer discretion to deny applications without requiring an IE
- ✚ Do not cap assessment fees. A more appropriate alternative to limit costs is to utilize to profession specific guidelines for time required and hourly fees.
- ✚ The review of the PAF should consider ways to increase appropriate utilization of the Pre-Approved Framework for initial treatment and address any barriers.
- ✚ Maintain/expand the PAF as an administrative mechanism to provide streamlined access to initial treatment for accident victims whose injuries/impairments are appropriate for the goods/services provided within the PAF.
- ✚ Do not create a cap on post PAF access to treatment, or other benefits, based on initial treatment decision to treat the accident victim within the PAF.
- ✚ Fairness requires that the catastrophic impairment criteria must allow full consideration of brain injuries and other psychological impairments. The processes for determination must allow the accident victim appropriate opportunity to have their impairments assessed.

Thank you for the opportunity to share these concerns with you. If I can provide any further information or clarification please feel free to contact me.

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