ONTARIO PSYCHOLOGICAL ASSOCIATION

Sept 17, 2019

# ONTARIO PSYCHOLOGICAL ASSOCIATION (OPA) RESPONSE RE: "CARE, NOT CASH" CONSULTATION

## INTRODUCTION

The OPA appreciates the opportunity to provide input regarding "Care, Not Cash". In our comments and solutions we are mindful of the need to address issues of cost control and the most cost-effective use of the dollars spent as well as timely access to care for those who are injured. The consultation paper restates the Government's priority to provide care to those who are injured in auto accidents and states,

> *The blueprint committed to ensuring that people hurt in auto collisions receive faster access to treatment and care. That's why the government is introducing a "Care, Not Cash" default clause so that a driver's auto insurance coverage will pay for treatment rather than cash settlements which may not be directly linked to recovery.*

The OPA shares the concern that too many accident victims face delays and barriers when attempting to access timely care. For these accident victims, later cash settlement does not replace the need for better access to timely care. Those with minor, and generally resolving, physical injuries are able to receive prompt care through the Minor Injury Guideline. However, those with more significant injuries require insurer prior approval for funding of any care. No funding is available for those with more serious injuries unless the insurer agrees. This need for prior insurer approval of care is particularly problematic for accident victims with psychological disorders, including brain injuries, whose injuries are not as visible as physical injuries. Accident victims with psychological disorders frequently encounter stigma and a presumption that their disorders are "not real" or do not require care. This results in delays and denials of their ability to access care. In fact, for patients with psychological disorders, the "default" is often insurer denial of care.

The OPA commends the government for its focus on improving timely access to care. Removing barriers and delays in access will automatically reduce the demand and proportion of funds spent on cash settlements. However, as is conveyed in the government's consultation paper, simply removing or restricting cash settlements is not sufficient to improve access to care. In fact, unless barriers to access are addressed, restricting cash settlements will actually have an unintended negative consequence of reducing access to care.

Below we respond to the Government's consultation questions regarding providing consumer protection and improving access to care as well as addressing cash settlements in the order presented in the consultation paper. We provide analysis and offer solutions regarding:

- improving timely access to care,
- avoiding and resolving disputes,
- improving the Insurer (third party initiated) Examination (IE) system, and
- identifying situations in which cash settlements are a necessary, cost effective solution to provide access to care.

## CURRENT STATE: CASH SETTLEMENTS

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

**Insurer denial of care is the main reason insured persons seek cash settlements:**

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. When care is denied by the insurer, this denial often sets in motion an adversarial process leading to seeking a cash settlement. Addressing the barrier caused by the insurer's denial of care resonates with the government's commitment to care.

It is our experience that most insured individuals seek legal counsel and cash settlements only after they have become frustrated with their claims experience. Those who have a good claims experience generally are satisfied with the services they receive through accident benefits, do not engage legal counsel, and do not seek a cash settlement of their Accident Benefits (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 may feel re-victimized. They often describe being "forced" to seek legal counsel and settlement. This is often the experience for accident victims with psychological disorders where the "default" is often insurer denial of applications for care.

**Cash settlements provide flexibility in the provision of care:**

In addition, there are some instances when the insurer and the insured person jointly determine that it is more consistent with the cost-effective, efficient, flexible rehabilitation for the injured person to assume control and responsibility for the management of their rehabilitation funding. These settlements provide more flexibility for the insured person and reduce transaction costs for the insurer.

***Consultation question 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)***

We are not responding on behalf of an industry and therefore do not have access to this data. However, it would be very useful to have access to this data for the industry as a whole and on a specific insurance company basis.

## IMPLEMENTATION DETAILS: CARE, NOT CASH DEFAULT

***Consultation Question 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)?***

**Improve access to care and prevent disputes:**

The best way to provide timely resolution of disputes regarding access to care is to prevent disputes in the first place. A large proportion of disputes, especially those that occur early in the claim, can be avoided.

Reducing treatment denials, allowing provision of care, 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. Reducing denials is consistent with the government's commitment to "Care not Cash" and an efficient, cost effective way to achieve this goal.

**Provide initial care without requirement of insurer prior approval:**

Some disputes can be prevented by allowing all injured individuals, with accepted claims, to access initial care without requirement of insurer prior approval, dispute, or IE. This would avoid up-front disputes regarding 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 immediate submission of a care plan signed by the insured person (similar to the OCF 23), compliance with fee schedules, and relevant Guidelines would provide additional cost control.

**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). This is especially problematic for injured persons with psychological disorders. Too often plans for care are denied without provision of a specific reason, often only the statement 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. These denials occur even when there is a referral and/or support from the family physician or other medical specialist with a diagnosis of a psychological disorder; a recommendation for psychological care; and a clinical screening or assessment has been completed by a psychologist that confirms these indicators 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 care by reasonably approving applications for treatment. While it is not the role of the insurer to direct care and they are not health professional case managers, 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.

- *Adjuster training:*

Adjuster training may include current information regarding: common types of injuries; resulting disorders; usual treatments; and range of generally expected outcomes. Training may also help to better inform adjusters regarding the effects of denial of timely treatment leading to greater disability and loss of income and therefore increasing ultimate costs.

Adjuster training is especially required regarding psychological disorders. It is too frequently assumed by the insurer that the person presenting with a psychological disorder does not require care and/or is exaggerating or malingering. This leads to a very high proportion of denials and delays in treatment. The unreasonable insurer denials also cause an unnecessarily high number of Insurer Examinations (IE). These in turn cause a burden on the injured person, delays, disruptions to care and costs, even when the care is ultimately approved.

- *Adjudication Guidelines:*

Adjudication Guidelines can provide direction for review of treatment applications including: expectation for contact with the treatment proposer 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; as well as 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 clinical determination. When there is contemplation of a medical reason for a denial, an IE should be required.

- *FSRA monitoring and enforcement of compliance with Adjudication Guidelines:*

There is a need for FSRA to monitor and enforce compliance with Adjudication Guidelines. The monitoring should include both the overall system as well as be responsive to complaints.

FSRA should be able to identify patterns of insurer behaviour which warrant further investigation. These might include, for example: lack of timely response, apparently excessive denials of applications for care, failure to provide a medical or other reason for a denial, or assertion of a medical reason without referral to an IE.

When these types of indicators, suggestive of non-compliance with adjudication guidelines are identified, FSRA should investigate, provide remedial direction, as well as institute meaningful penalties.

The results of the FSRA investigations should be available to the public to assist in making informed decisions regarding expected insurer behaviour when purchasing insurance.

**Improve the IE system to foster earlier resolution of disputes regarding care:**

When an IE is required there are a number of improvements that can readily be made to the IE system. These changes 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 for assessor qualifications, Assessment Guidelines, standardization of forms, as well as FSRA monitoring and compliance mechanisms. In addition, there should be further exploration of FSRA rostering of assessors and alternative assessor selection processes. *(See also OPA submission to the Assessment Reform Working Group, attached)*

- *Standards of Assessor Qualifications:*

Assessor qualifications include requirements such as minimum standards for education, training, and relevant clinical practice.

- *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 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 enforcement of compliance with Assessment Guidelines:*

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

- *FSRA rostering and exploration of alternative assessor selection methods:*

Further review of the potential for a FSRA roster of licensed assessors is required. In addition, the potential benefits and costs of alternative models of assessor selection should be explored.

**Improved, accessible, fast track, dispute resolution for plans of care:**

In those instances 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 track process dispute resolution process (DR) is required. The DR process must be modified to address the goal of earlier resolution of disputes to provide decisions regarding timely care which will reduce the proportion of funds that go to later cash settlements.

Various options have been raised for alternative dispute resolution process. These alternatives require further multi-stakeholder exploration and development. In addition, there is a need to address the injured person's need for legal advice in order to be able to have fair access to participate in the DR process.

***Consultation Question 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.***

**Re-institute "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.

In a "pay pending dispute" system the default is to provide funding for care. In the pay pending dispute model the health professional continues to submit applications for care signed by the insured person. While the insurer is only required to pay "reasonable and necessary costs" care is able to proceed and the insurer's obligation to pay is presumed unless they dispute the care plan. Care continues during the period of dispute. If the insurer demonstrates that the costs were not reasonable and necessary they are not obligated to pay. Thus, health professionals have financial incentives to self-monitor and only provide care that is, and will be found to be, reasonable and necessary.

Cost control under pay pending dispute is also provided by limiting the insurer's obligation to payments that are 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 pay pending dispute would facilitate timely access to care. Pay pending dispute would make the default care, not denial.

**Exceptions to allow cash settlements:**

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 only when the AB system fails to provide funding for treatment that the insured person seeks a cash settlement.

At this time, other than for MIG care, which is only available for those with “minor” physical injuries, the insurer has the authority to deny applications for care from the injured person’s treatment providers. The pattern of insurer denials of care applications is especially problematic for accident victims with psychological disorders. At times these denials may be, or appear to be, arbitrary and unreasonable. The insurer is not obligated to secure an IE on their decision to deny an application. The adjuster is able to make a “binding” clinical decision about care needs. Unless the treatment is approved by the insurer or in dispute resolution, there is no funding for treatment provided by the insurer. There appears to be some confusion about the “binding” nature of the insurer’s decision pending dispute resolution. All invoices for services must be linked to a treatment plan approval number. Without this approval number, the invoice cannot be submitted to the insurer for the services. Therefore, there is no possibility of insurer payment.

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 often will not be able to pay for legal advice during the dispute process and would be precluded from effective participation. 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 fairly and effectively participate in dispute resolution will become highly restricted. Without cash settlement and the possibility of funds to engage legal advice, the injured person’s ability to access their benefits may be effectively eliminated. Therefore, it is necessary to include exemptions to the restriction on cash settlements as well as to address the imbalance in the injured person’s ability to engage in dispute resolution.

- *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 to obtain timely treatment. It is not possible for a customer to know if they will encounter this situation of insurer denial of care at the time of purchase of their insurance policy to make an informed and binding decision. Therefore, it is necessary to allow when 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 care giver from a distance:*

The example provided by the government is that the injured person moves or lives 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.

- *Children and injured persons with a substitute health care decision maker:*

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 long 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:*

The process to determine if a person has a Catastrophic Impairment can be long. Therefore it is recommended that a settlement be allowed, if mutually agreed upon by the insurer and insured person, when there has been a Catastrophic Impairment application (OCF 19) submitted.

In most instances the completion of the OCF 19 does not occur until the permanence of the injury is determined which usually requires at least two years post injury. Submission of the OCF 19 also requires that a health professional confirm and "certify" that the injured person has a catastrophic injury. Allowing settlement at this point in the process will avoid the delays and costs associated with catastrophic impairment determination which can take several more years.

***Consultation Question 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 is made, it should only be effective after policy renewal as the customer would require an opportunity to consider their options.

***Consultation Question 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.***

**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 create a greater power imbalance between the injured person and the insurer and remove an important mechanism for consumer protection. Removal of cash settlements risks 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. The insured person will have less recourse to challenge this 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.

**Reduced access to credit and "protected accounts" to pay for timely care:**

Some health professionals have provided some timely care on a delayed payment arrangement, or a "protected account". In these instances the health professional provides timely services anticipating that they will be paid at settlement. If cash settlements are precluded, this practice will no longer be possible.

Prohibition of cash settlements would also likely interfere with the ability to obtain credit and borrow funds to pay for timely care.

## IMPLEMENTATION DETAILS: OPTIONAL BENEFIT (CASH SETTLEMENTS)

### *Consultation Question 7: What terms, conditions, limits, or other factors should the government consider in designing a cash settlement optional benefit?*

**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 MVA, what will be the costs of care, what services are available under the public system, and what the claims experience will be. The information that is most readily available is limited to cost of premiums to purchase insurance. This tends to be determinative.

**Contradiction of a need to pay extra to ensure funding for care:**

A decision regarding an option for cash settlements may be particularly challenging. It is particularly confusing to determine 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 should be 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 cash settlements if they are injured.

## SUPPORTING IMPLEMENTATION: CONSUMER EDUCATION AND AWARENESS

### *Consultation Question 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.

### *Consultation Question 9: What other opportunities exist to ensure consumer awareness / education?*

A multi-stakeholder group may consider various methodologies for provision of information.

## ADDITIONAL COMMENTS

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

**Comparison to the WSIB:**

Much of the discussion regarding the expectation that "Care not Cash" will improve access to care appears to have been based on incorrect assumptions regarding similarity between the WSIB system and the auto insurance system. However, the mechanisms employed in the WSIB are not readily transferrable to the auto insurance context. The Marshall report recommended importing some features of the WSIB system into the auto insurance system without full consideration of the differences in the context or incorporating all of the consumer protection mechanisms provided in the WSIB system. One recommendation is described as "Care, Not Cash". In the WSIB system there is a focus on providing timely and ongoing care to foster rapid and sustained return to function including work. If needed, ongoing, life time care is funded with no time or dollar limits. In contrast, the private auto insurance system has many control mechanisms, dollar caps, and time limits on access to care.

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, see their role as facilitating access to care and they have the authority and expertise to do so.

## CONCLUSIONS:

The OPA appreciates the opportunity to comment on "Care, Not Cash" option. We agree that the focus of the Accident Benefits should be to provide funding for timely access to care. Injured persons with psychological disorders experience additional denials of care applications which cause delays and barriers in access to care which must be addressed.

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, it appears that some insurers have focussed more narrowly on removal of cash settlements.

The OPA agrees that it is important to focus on improving timely access to care and on reducing the proportion of accident benefit 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 prior to and simultaneous with implementation of these restrictions, changes are made to provide consumer protection and access to accident benefit funding of care. Without implementation of solutions to improve the claims experience and ensure better access to care, removal of cash settlements will in fact reduce rather than increase access to care. *(See above responses to Questions for description of these cost-effective solutions which can be readily implemented to provide consumer protection and improve access to care.)*

An adjuster claims adjudication process which respects the role of the patient and responsibility of treating health professional responsible for determining reasonable and necessary care would enhance access to care, reduce the number of IEs and disputes, and would reduce the pressure for cash settlements. When the system fails to provide timely access to 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.

If "Care, not Cash" as a default is adopted there are a number of issues that need to be addressed prior to and simultaneously with implementation to ensure that consumer protection and access to care is not reduced. The

issues raised in Government's consultation paper acknowledge the need for this balance. The solutions discussed above include:

- Reinstatement of "pay pending dispute";
- Creation of a phase of initial care that is presumed to be approved;
- Improvement of insurer adjudication practices, including for applications for care of psychological disorders;
- Improvement of the IE system;
- FSRA monitoring and compliance enforcement;
- Creation of a streamlined dispute resolution (DR) process for plans of care;
- Addressing the power and knowledge imbalance in DR between the insurer and the insured person if the funds to pay for legal advice are removed by restricting cash settlements;
- Creation of explicit exemptions to allow cash settlements even when the option has not been purchased.

The OPA would welcome the opportunity to work with government and other stakeholders to develop the details and implementation of these solutions.

Please contact me if the OPA can provide any further information, clarification or be of assistance to work together to improve the system so that accident benefit funds are utilized in a more cost-effective manner to provide timely access to care.

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