FSRA CONSULTATION ON AUTO REFORMS

HEALTH SERVICE PROVIDER (HSP) FRAMEWORK REVIEW

STATUTORY ACCIDENT BENEFITS SCHEDULE (SABS) GUIDELINES REVIEW

THE HEALTH CLAIMS FOR AUTO INSURANCE (HCAI) SYSTEM REVIEW

In Ontario's auto insurance system, the burden of red tape has grown beyond its intent, compromising care and driving up costs. True reform lies not in more layers of oversight but in streamlining for efficiency, transparency, and a focus on patients.

Anthony Grande PT

A Call for Open-Minded Reform: Reading with Purpose and Possibility

I invite you to read this document with an open mind and a highlighter in hand. This isn't a typical analysis—it's a call to think holistically and consider the evolving needs of Ontario's auto insurance framework and accident benefits system to create a long term sustainable product for all stakeholders. Over the past two decades, regulatory changes have often added layers of complexity without improving the auto insurance product or outcomes for consumers. These accumulated systems speak for themselves in terms of their unintended consequences, and now, we have a unique opportunity to re-evaluate and simplify.

Please don't dismiss ideas that seem beyond the usual parameters or questions that may initially seem out of scope. Instead, approach this with a solutions-based mindset, open to new perspectives and a growth-oriented approach.

Solutions can come from everywhere, and often do, when we step beyond our usual boundaries, leaders know this to be true. This consultation is a chance to listen to all voices and explore innovative answers—moving away from a fixed mindset of "this is the way it is" and towards "how can we make this better?"

Thoughtfully engage with this material, let's all set aside preconceived notions about post-accident care that may hinder our ability to effectively address the true needs of those affected.

Executive Summary

This consultation response addresses the critical issues impacting Ontario's auto insurance and Health Service Provider (HSP) licensing frameworks, highlighting how current practices affect healthcare providers, patients, and the broader system. This response advocates for reforms to improve patient outcomes, reduce administrative burdens, and restore fairness in a framework increasingly misaligned with healthcare realities.

Key Issues and Recommendations

1. **Streamlining HSP Licensing**

The HSP licensing system is redundant for clinics owned by regulated healthcare professionals, adding unnecessary costs and administrative burdens without proven benefits in fraud prevention. Removing HSP licensing for regulated professional owned businesses would reduce barriers to care and better allocate resources to higher-risk, unregulated services, such as tow trucks body shops and allowing FSRA to focus on unregulated healthcare practices owned by non-healthcare professional who do not reprt to a healthcare college.

Ownership Models for Healthcare Providers

An essential recommendation within this response is to encourage ownership models that empower regulated healthcare professionals, particularly in the framework of clinic ownership. By supporting healthcare professional ownership, Ontario's system can prioritize patient care within an ethically grounded model, minimizing external financial influences. This approach aligns with other successful healthcare frameworks and ensures that providers, who are best positioned to understand patient needs, retain control over clinical decision-making.

2. **Modernizing Statutory Accident Benefits Schedule (SABS) Guidelines**

SABS guidelines for Minor Injury Guideline (MIG) caps and Professional Services Guideline (PSG) rates remain outdated, failing to address inflation and the increased complexity of care. Recommended updates include increasing the MIG cap to $15,000 and adjusting PSG rates to $400 per 50-minute session to reflect current healthcare inflation. Attendant care rates should also be revised to $55–$60 per hour, which aligns with fair compensation for the specialized care required Additionally, removing the three 4-week block structure within the MIG will allow healthcare professionals greater flexibility to deliver care in a more patient-centred manner, addressing individual needs and recovery timelines. Reinstating Form 1 assessments for physiotherapists and chiropractors would further expedite access to necessary services and improve patient outcomes.. Allowing

these professionals to perform assessments that align with their expertise will further reduce treatment delays and improve patient outcomes.

3. **Eliminating all Preferred Provider Networks (PPNs)**

PPNs (open and closed) incentivize care decisions based on financial gain over patient need without benefits to consumers, complicating patient access to unbiased, quality care. Their removal would support transparency, fairness, and patient-centred care by preventing insurers from directing patients to selected providers for financial reasons.

4. **Improving Adjuster Training and Oversight**

Inconsistent training and high turnover among insurance adjusters lead to delays, misunderstandings, and unnecessary disputes. Standardized training on healthcare practices and a regulated code of conduct for adjusters would mitigate “cowboy behaviour,” enhancing system efficiency and care quality.

5. **Addressing the Health Claims for Auto Insurance (HCAI) System Inefficiencies**

HCAI’s outdated, fragmented processes impede care delivery and increase administrative costs. Enhancing HCAI with features such as real-time adjudication, attachment support, and transparent claim decision-making would streamline workflows, reducing delays and errors for healthcare providers and patients.

6. **Implementing a FairCARE Dispute Resolution Model**

Existing dispute mechanisms, including the License Appeal Tribunal (LAT), are slow, costly, and litigation-driven. FairCARE proposes a randomized, impartial second-opinion framework to expedite patient care and reduce unnecessary legal costs, using professional reviews to improve accuracy and fairness.

7. **Involving Healthcare Providers in Policy Development**

Ontario’s auto insurance system has struggled with sustainable solutions is the lack of meaningful involvement of healthcare providers in policy development. Excluding front-line professionals from decision-making has created a framework misaligned with care delivery needs, which now impose burdensome administrative requirements and enforce rigid structures ill-suited to complex patient care. Policymakers must actively engage healthcare providers, leveraging their insights to create balanced policies that truly meet the needs of patients and consumers, ensuring long-term sustainability.

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Acknowledging Progress and Addressing Systemic Challenges

My Heartfelt Acknowledgement of the Ministry of Finance's Consultation Initiative

As a healthcare professional with three decades of dedicated service to patients, I am immensely encouraged by the Ministry of Finance's decision to revisit long-standing issues that have impacted both healthcare providers and consumers in Ontario's auto insurance system. This is a long-overdue and much-welcomed step that shows true leadership and a commitment to fostering a more balanced and effective framework. I salute the Ministry's wisdom and prudent judgment in initiating this consultation process—it is a clear sign that change is on the horizon, and that patient care, fair compensation, and sustainable practices are at the forefront of their thinking.

It is refreshing to see that the Ministry of Finance recognizes the need to review and update outdated regulations, especially those that have remained unchanged for over a decade. Unlike previous approaches that focused on the absence of a legal mandate to review fee structures, the Ministry's forward-thinking strategy demonstrates an understanding of the economic realities that healthcare professionals face. The Ministry's approach reflects a deep understanding that reviews to fee structures are not just a legal obligation—they are a financial and ethical necessity for maintaining a fair, efficient, and patient-centred system.

In contrast to the language used in previous documents, which tended to downplay the economic challenges of healthcare providers, the Ministry of Finance is taking a holistic view of the factors that drive costs and impact patient care. Rather than relying on rigid interpretations of what is "legally required," the Ministry is demonstrating a thoughtful and progressive understanding of the need for balance—ensuring that service providers, insurers, and consumers all benefit from a system that works fairly for everyone.

The Ministry's decision to open these consultations shows a willingness to think differently and, most importantly, to listen to the voices of those who deliver care every day. By acknowledging the need to revisit fee structures—such as the Professional Services Guidelines (PSG) and Minor Injury Guidelines (MIG)—the Ministry is paving the way for an insurance framework that ensures fair compensation for healthcare providers, while still considering the broader impact on auto premiums and consumer protection.

This new direction reflects a deep understanding that maintaining static rates amidst rising operational costs, inflation, and the challenges brought on by the pandemic simply isn't sustainable. It is wonderful to see the Ministry of Finance not shying away from these complex issues but instead stepping up to reimagine a system that will ultimately lead to better patient outcomes, more equitable compensation, and greater market efficiency.

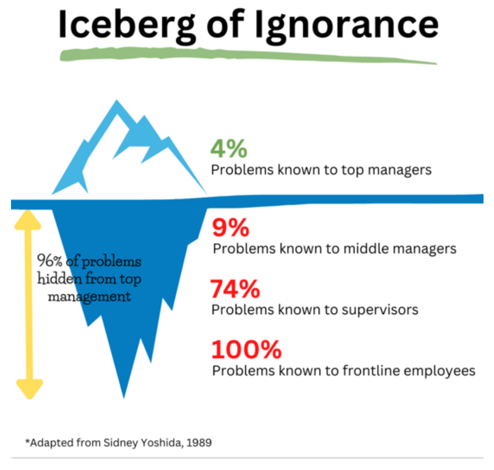
Factors such as investment returns, administrative efficiencies, and competitive forces also play roles in determining premiums, the Ministry is showing that the solution to sustainable auto insurance doesn't rest solely on the shoulders of healthcare providers. It's about creating a balanced and fair framework, where all stakeholders—insurers, providers, and patients—contribute to the solution.

I commend the Ministry of Finance for their prudent and proactive approach to resolving these long-standing challenges. Their leadership along with the Premier of Ontario in this consultation process will benefit consumers in obtaining value for money, and ensure that consumers receive the care they need without unnecessary barriers. A future where Ontario's auto insurance system supports high-quality care, economic fairness, and a better balance for all is a sustainable one.

Thank you to the Ministry of Finance and the Premier for being willing to think beyond the limitations of previous frameworks, for being bold, and for embracing a more compassionate, forward-thinking vision for the future of auto insurance in Ontario. Thank you for asking healthcare professionals on the front lines of the delivery of these benefits what is broken and looking beyond the Queens Park bubble of lobbyists and financial services regulators to make a more informed decision to improve the province of Ontario.

This "Iceberg of Ignorance" illustrates how crucial it is for decision-makers to look beyond the narrow perspectives within financial services. By seeking insights from frontline healthcare professionals, who see 100% of the real issues, the government is taking essential steps to uncover and address the root causes of inefficiencies and gaps in patient care.

Anthony Grande



Statement:

Imagine if we treated palliative care the way we treat rehabilitation for accident victims—underfunding each person's care to the point where healthcare professionals were forced to rush from patient to patient, limiting time with those in their final moments of life. The thought of reducing care in such a critical phase, denying people the dignity of a thorough, compassionate assessment and treatment plan, would be unthinkable. Yet, this is the reality for accident victims navigating rehabilitation under our current system. The limited resources and financial constraints rob them of the time and attention they need to heal properly. Like palliative care, rehabilitation should be a journey that centres around the individual, offering the chance for meaningful recovery, reassessment, and patient-centred care. Instead, we have a system that pushes healthcare professionals to cut corners, creating inefficiencies that hinder true recovery. It's time we ask ourselves: are we truly giving accident victims the care they deserve, or are we robbing them of their chance at recovery in the same way it would be unacceptable to rob a person of dignity at the end of their life?

Over the past two decades, Ontario's statutory accident benefits system has evolved into a complex framework that has introduced inefficiencies and redundancies, driven by a repeated attempt to reinvent processes rather than building on existing, effective healthcare regulatory frameworks. The result is a system that is neither LEAN nor efficient—two qualities that should be at the heart of any well-functioning service delivery model.

Key areas of inefficiency include the HCAI invoicing system, the health service provider licensing framework, and the closed Preferred Provider Network (PPN) used for second-opinion examinations. These systems have added layers of administrative burden without delivering proportional improvements to patient outcomes or care delivery.

Moreover, we have neglected critical areas such as the professional services guidelines, the Minor Injury Guidelines (MIG), and the attendant care guidelines. These frameworks have remained outdated, the MIG and its predecessor the PAF were created by financial services with no consensus from healthcare providers or any approvals. These fee caps have complicated the delivery of care and resulted in increasing operating costs across the system downstream. While insurers are able to pass the early-stage additional administrative costs on to consumers in the form of higher premiums, healthcare professionals—constrained by fee maximums—are left to absorb rising operational expenses, further straining the system for them there is no long term, and many have left the system altogether.

Instead of leveraging existing, proven frameworks developed by self-regulated healthcare colleges, since 2003 we have created new systems that add complexity without adding

value. By starting from scratch and disregarding what has historically worked, the statutory accident benefits system has become increasingly dysfunctional.

This submission will highlight areas where inefficiencies exist and propose practical, LEAN solutions to improve the sustainability of our auto insurance system. By eliminating redundancies and focusing on streamlining processes, we can create a more efficient and transparent system that delivers better value for consumers, reduces premiums, and improves care for accident victims.

As Dostoyevsky once said, "The greater the intelligence, the greater the suffering." This rings painfully true for healthcare professionals in our current auto insurance system. These kind and intelligent individuals—encouraged from a young age to use their compassion and intellect to help others—are now enduring immense frustration and hardship as they navigate a system that makes it nearly impossible to deliver the high-quality care they were trained to provide. They are suffering, not for lack of skill or will, but because the system has forced inefficiency and unfairness upon them. I believe that a more efficient, transparent, and fair system will not only ease their burden but will also benefit everyone involved—accident victims, healthcare professionals, and the broader community. By addressing these inefficiencies, we can restore dignity to both the healthcare professionals and the people they serve, allowing compassion and expertise to flourish where they are most needed.

SECTION 1:

A response to the Health Service Provider (HSP) Licensing Framework Review

"Don't reinvent the wheel."

— Proverb

October 2024

Introduction - HSP Consultation Section

I am deeply appreciative of the Premier of Ontario, the Minister of Finance, and the government as a whole for their commitment to consulting with regulated healthcare professionals impacted by the HSP licensing framework. This outreach is a significant step towards fostering collaboration and ensuring that the voices of those delivering care directly to car accident victims are heard.

The goal of this document is to support the Ministry of Finance and FSRA in finding solutions that reduce red tape without compromising patient care and enable the creation of a sustainable auto insurance treatment framework for all. It is also to ensure that local physiotherapy clinics and rehabilitation centres remain sustainable, thriving, and able to provide critical care across all treatment frameworks.

The Health Service Provider (HSP) licensing framework was created to deal with IBC claims of in the early 2000's to be $1.3 billion in healthcare fraud allegedly committed by clinics that provided rehabilitation to accident victims—a figure that we now know was drastically inflated by the Insurance Bureau of Canada (IBC) and ultimately inaccurate. Today we know, the actual amount invoiced for direct patient care through HCAI as noted in the Health Claims Database is approximately 645 million consisting of $342 million through treatment clinics, with an additional $303 million for insurance-initiated examinations in 2022. This is a far cry from 1.3-billion-dollar IBC put forward.

This HSP licensing framework was established on a misleading premise like many other auto insurance reforms since 2003 and has unfortunately introduced significant administrative and financial burdens for already regulated healthcare providers. These challenges not only strain healthcare providers but also impact patient care by failing to recognize the consumer protections already inherent in existing healthcare regulatory frameworks.

HSP licensing was created due to an incomplete understanding by financial services of consumer protections that already effectively existed within existing healthcare regulatory college frameworks.

As a regulated healthcare professional, I have seen how the HSP framework, in its current form, negatively impacts the ability of regulated healthcare professionals to serve patients efficiently and thus providing less value to auto insurance consumers.

This section of the submission seeks to offer collaborative feedback on how we can streamline the HSP licensing regime and processes to better support auto insurance

consumers, healthcare providers and, most importantly, the patients we serve, while maintaining the integrity of Ontario's auto healthcare framework and insurance systems.

Foreword:

After reading through the consultation document, it became evident to me that there is a difference in the thinking that guides healthcare professionals compared to that of financial services employees.

The oversight mechanisms for these two domains are different—and for good reason. In healthcare, regulation is built upon ethical frameworks, where patient care, professional judgment, and context-sensitive decision-making are at the forefront. In contrast, financial services operate on compliance-driven models, where rigid protocols, timelines, and standardized processes ensure regulatory adherence.

When we apply the same types of oversight currently used in financial services—like what we see in the Health Service Provider (HSP) licensing—to healthcare professionals, who have already been regulated for generations by well-established ethical oversight bodies, such as healthcare colleges, the disconnect becomes obvious.

Healthcare professionals look at the HSP compliance and administrative heavy rules-based requirements, with their strict five-day timelines and procedural rules, and ask themselves, "But the invoice is accurate — isn't that the point?" These arbitrarily chosen, unscientific dates chosen in a boardroom in an ivory tower somewhere don't reflect real world hurdles or realities, and they definitely don't have correlation or causality to invoice fraud.

HSP licensing has harmed healthcare in a variety of ways one of which is the arbitrary rules and dates with no rationale came to be. For example, the HSP timeline framework to remove a professional from a roster is understandable, yet how the ten-day rule came to be is unclear and is in conflict with other HSP rules. Many providers state this rule and many HSP rules were created without input from healthcare professionals and the rigid rules-based systems cause harm since they have unintended consequences.

For people outside of healthcare, it is challenging to grasp the depth and degree of oversight within the ethical framework of healthcare regulator. To offer a relatable comparison, consider driving a car:

- **An ethical framework:** is like being a responsible driver. You're expected to use your judgment to navigate safely, consider the conditions around you (such as weather, traffic, pedestrians), and make decisions that protect both yourself and others on the road. You're guided by the principles of safety, responsibility, and consideration for others. This requires constant awareness, adaptability, and a sense of moral duty. There's trust that you will make the right decision, even when the rules aren't clear, or situations are unique.

- **An administrative heavy rules-based framework** is like following traffic laws to the letter without regard for the real-world situation. Imagine you're driving, and the rule says you must always stop for 5 seconds at a stop sign, regardless of whether the road is empty or there's an emergency. You follow the rules exactly, ticking off the boxes as you go stopping at the stop sign, staying under the speed limit, etc., but without considering context. This system is rigid, and while it may ensure compliance, it doesn't account for the complexities of real-world driving situations.

In healthcare, the **ethical framework** is like the responsible driver—healthcare providers constantly assess each patient's unique situation, applying their professional judgment and moral duty to ensure the best care. In contrast, a **checkbox framework** is like following rigid rules, which may overlook the complexities of individual patient care, leading to impersonal or even ineffective treatment. The checkbox framework is the driver who won't move to the side at a red light with an ambulance behind them.

Just as responsible driving requires judgment beyond just following road signs, healthcare professionals need the flexibility to make ethical patient-centred decisions, which goes far beyond simply ticking boxes.

If you're a motorcyclist or cyclist, you know that even when you follow all the rules of the road perfectly, you're not guaranteed safety. You can stop at every sign, signal at every turn, wear the best safety gear, and still find yourself in an accident due to factors beyond your control. This experience highlights the limitations of purely rule-based, compliance-driven systems.

Healthcare is best served and delivered within ethical frameworks that allow professionals to use their training, judgment, and moral responsibility to make the right decisions for each patient—just like how motorcyclists and cyclists are best served by real-world awareness. Forcing Healthcare into rigid, dual oversight systems is inefficient and harmful, as it strips away the flexibility needed to provide high-quality care. That's why healthcare colleges built on ethical frameworks have been so effective in their management of healthcare professionals while at the same time protecting the public for generations. That is also why HSP licensing is a step back in oversight for regulated healthcare professionals and increases risk to consumers.

The purpose of this submission is to bridge what I see as an obvious divide in methodology and approaches between healthcare professionals and financial services oversight, a divide that is creating significant inefficiencies within the auto insurance treatment framework. This divide is unfortunately growing, which I hope can stop.

Financial services are seemingly uninterested in concerns outside of their rules-based framework, which is harmful to the auto insurance consumer in the long term. When a more sensitive measure (professional ethics) notes potential issues (auto insurance PPN's)

that abuse the rules but are not yet a strict violation, bureaucracy needs to take heed before the situation is out of control.

The growing divide is evident as healthcare voices are increasingly isolated from the auto insurance conversation despite being on the front lines. This divide is growing in 2024 with the recent dissolution of the FSRA Health Service Provider Advisory Committee. Whereas In 2023 the Board Chair of the FSRA Ms. DiLaurentiis, stated the FSRA listens to everyone and touted the presence of the Health Service Provider Advisory Committee as being part of an agency that "listens". In 2024 the Former CEO stated the committee is solely to speak about invoicing issues and not raise concerns outside of scope.

Despite its short tenure and mandate reduction, the HSP advisory committee was the only platform where healthcare professionals could raise concerns to FSRA management about PPN's and insurer behaviour and unfair HSP audits, not addressed by the legal compliance framework, and now it's gone.

The previous governments decision to create a duplicate licensing framework that includes already regulated healthcare professionals in an attempt to control the participants in the auto insurance framework cast a net too wide. We have included healthcare professionals who own clinics that now find themselves at a disadvantage with more red tape than business owners who have no healthcare college regulatory oversight.

We have created inefficiencies that are harming consumer benefits, destabilizing the sustainability of insurance pricing, weakening healthcare delivery, and ultimately compromising patient outcomes. Moreover, the system as it currently stands is not giving value for money.

As a healthcare professional regulated in Ontario, my conduct is governed by my healthcare college, and I have a duty to present ideas that improve patient care, enhance the entire system efficiency, and promote fairness in healthcare delivery for all consumers, patients and stakeholders, all while upholding the highest ethical and professional standards. My goal is to help create a system that truly benefits everyone—patients, providers, and insurers alike.

Regulatory duplication causes frustration, and healthcare professionals are already bound by ethical and professional standards that emphasize patient care and ethical behaviour in all aspects (including invoicing). The imposition of a financial services regulatory model doesn't account for the nuanced, patient-centred nature of healthcare. My hope is that this response will bridge the gap in understanding between these two perspectives. At the end of the day, I believe that everyone wants the same outcome: a system that is efficient, delivers on its promises, and is fair to all participants—patients, providers, and regulators alike.

It is my hope that the insights presented to the Ministry of Finance and financial services will bridge the existing gaps and guide us toward an ethically grounded LEAN-driven system—one that eliminates waste, streamlines processes, and maximizes value for patients, providers, and insurers alike. By adopting a more efficient approach, we can avoid the pitfalls, such as unnecessary complexity, inefficiencies, and misallocation of resources, while ensuring sustainability and improved outcomes across the entire system.

Imposing rigid financial compliance models on ethically driven healthcare professionals undermines care delivery and system efficiency; instead, relying more on established existing and cheaper lean, ethically grounded healthcare college oversight will maximize value for patients, providers, and insurers alike.

It's hard for people in one system or circumstance to connect to people in another system of circumstance, I will endeavour to bridge that gap. In closing, I humbly hope that these consultations will be guided by wisdom to recognize the best path forward and by prudence to enact this vision effectively for the benefit of all.

Context and Considerations

Red tape acts as a hidden tax on consumers, but its impact is not evenly felt by all stakeholders.

It is widely understood that the cost of administrative burdens is ultimately passed on to auto insurance consumers.

Yet for insurance companies, these system-wide administrative costs can become a source of profit rather than a simple business expense, particularly when the product, like auto insurance, is mandatory. For healthcare professionals we cannot pass these costs along.

Expensive regulatory programs and regulatory requirements such those found within the auto insurance framework, increase the costs of doing business for everyone in the sector. The red tape throughout the treatment framework including HSP licensing is a significant driver of cost for healthcare professionals but also for insurers since the net cost healthcare professionals pay to FSRA does not cover the HSP licensing regime so insurers or the regulator pick up the difference.

Imposed by the previous government the red tape is something—no market player can avoid. Healthcare professionals must absorb them, yet insurers can justify passing those costs onto consumers. However, the problem is most obvious when we consider the numbers not just as a percentage of costs passed along, but in real dollars.

Consider this: if administrative costs for the insurance industry were $1 million, with a 5% markup, that adds $50,000 in profit passed onto consumers. But if those administrative costs balloon to $1 billion, that same 5% markup results in $500 million in extra profit, extracted from consumers. The numbers grow so large that it becomes a lazy way to generate profit. There's no increased risk for insurance companies in navigating these burdensome environments—these costs are simply passed along, leaving the consumer to bear the burden.

In Ontario, consumers are paying more for auto insurance every year, and considering we have less accidents than ever, a large portion of that is driven by ever increasing unnecessary administrative costs that just keep the system going.

Since 2014, HSP licensing has not fulfilled its mandate to uncover fraud but has instead added unnecessary red tape and costs to the auto insurance system. It has also imposed unfair and arbitrary compliance requirements that are nearly impossible to meet within the practical timelines businesses can meet.

I will discuss how this licensing has hurt our Ontario economy and impacted the over 4,900 healthcare practices that are not only focused on helping car accident victims recover but treating patients within other frameworks as well, the result is every type of patient suffers due to this red tape.

Regulated healthcare professionals who own and manage their practices believe the government should eliminate the HSP licensing requirements for clinics owned and controlled by regulated healthcare professionals like physiotherapists and chiropractors. In the long term, many believe a model like the pharmacy Act, where clinics are primarily owned and operated by regulated healthcare professionals is the best possible outcome for sustainability for all stakeholders.

HSP Licensing – No Real Benefit

Health Service Provider (HSP) licensing was imposed on healthcare professionals in Ontario by the previous government. Typically, a license grants permission to do something that would otherwise be prohibited—such as a driver's license allowing someone to operate a vehicle.

HSP licensing did not improve direct billing from insurers, it did not improve the number of direct payments we receive from insurers, nor did it allow access to HCAI.

Healthcare professionals were already invoicing through the Health Claims for Auto Insurance (HCAI) system and as a result submitted and received payments directly from insurers for many years prior to licensing.

Healthcare professionals gained no additional protection from bad insurer behaviour through licensing. Many healthcare professionals mistakenly believed that licensing would provide a platform to address insurer behaviour issues, but this has not been the case.

Before the licensing system, financial services argued they had no obligation to address complaints from healthcare professionals about insurer mistreatment, as healthcare professionals were not considered the insurers' clients. This remains unchanged.

A LEAN and fair system is the most sustainable type of auto insurance framework, HSP licensing does the opposite.

If we fail to address the true cause of out-of-control rates (red tape) and continue doubling down on failed policies put forth by the previous government. Insurers will need rate hikes based on out-of-control system operating costs and the market will consolidate more since the barriers to entry into the market for new insurers will be too high, resulting in skyrocketing premiums, and less choice with fewer options for consumers. (Some say we are almost there.)

This approach harms not only healthcare professionals, who face greater administrative burdens, but also auto insurance consumers, who bear the financial brunt through higher premiums and reduced coverage. Without evidence-based reforms, we'll see a system where prices keep rising, yet there's no accountability or transparency regarding where these extra costs are coming from.

We must demand transparency: show us the documented invoice fraud uncovered in the past 10 years of HSP licensing, any regulated healthcare professionals jailed for auto insurance fraud, and the verified societal cost of these claims. Until we see clear, substantiated data, unverified figures should not drive public policy or pricing that impacts millions.

1.3 Billion Dollars in Auto Insurance Fraud?

For decades the insurance industry repeatedly stated that auto insurance fraud in Ontario was a 1.3-billion-dollar a year crime perpetrated by healthcare clinics.

I say, exaggerating losses to government and their agencies to manipulate insurance reform is no better than a person exaggerating their losses to an insurance company in the event of an automobile accident.

In 2011 the Insurance Bureau of Canada (IBC) hired KPMG to ascertain the extent of fraud and came up with a number in the range of 770 million and 1.6 billion. The industry chose to promote the number of 1.3 billion, and in the UK this number coincidentally was the same yet. Yet those numbers were never validated.

"He who pays the Piper, Calls the tune."

Today, we have Health Care Database numbers that tell a real story, the HCAI data shows the total invoicing annually for all treatment is 645 million dollars and of that the direct patient care provided by independent healthcare clinics is approximately 367 million with the rest 278 million being insurance examination to dispute treatment requests. Attendant care is not submitted through HCAI at this time.

Historical Rationale for HSP licensing

HSP licensing was justified based on two misconceptions:

1- financial services regulators and government trusted and accepted the insurers' unverified claim of $1.3 billion in annual fraud without question, and
2- financial services failed to recognize the extensive regulation healthcare professionals already undergo through their healthcare colleges, making the additional licensing redundant.

However, we now know that the $1.3 billion figure was not based on factual data. Today, the reality is much clearer: the total annual amount invoiced through the Health Claims for Auto Insurance (HCAI) system, including all treatments and insurance examinations, is only **$645 million**. Of this, only $368 million accounts for direct treatment costs, while $277 million is spent on insurance examinations. This stark contrast highlights the exaggeration of the original fraud claims.

Here we have excerpts from the Ontario Standing Committee on General Government from Monday 28 May 2012. https://www.ola.org/en/legislative-business/committees/general-government/parliament-40/transcripts/committee-transcript-2012-may-28#P840_225322

Mr. Fred Gorbet, was the **chair of steering committee of the auto insurance fraud task** force and he stated with regards to the 1.3 billion:

> *"The number that has been around for almost 20 years, I believe, is the number $1.3 billion. We tried to figure out where that number came from; we could not.* ***We could not really satisfy ourselves that it had credibility."***
>
> When questioned by MPP Jagmeet Singh:
>
> **Mr. Jagmeet Singh:** Sir, just to clarify some points, the $1.3-billion figure that's been used has been used for about 20 years, and based on your research, that number doesn't seem to be supported by any research that you have. Is that correct?
>
> **Mr. Fred Gorbet:** *We could not find any research we thought was credible that could support it in today's marketplace.*
>
> In Response to a comment by MPP Rosario Marchese:
>
> **Mr. Rosario Marchese:** A quick question, though, on the whole issue of the $1.3 billion that the insurance companies say is related to fraud. Did you look at their numbers or their studies to see whether or not it jibes with any of the studies you're doing?
>
> **Mr. Fred Gorbet:** *We did. We looked at some. Some of the support people for the task force looked at some of those studies, and some of the steering committee members looked at some of those studies. What we could find was very dated and used a different methodology than we think is the appropriate methodology now.*

As a result, the FAIR Association and others would comment the following:

> ***"The IBC assigned a 1.3 billion dollar a year loss figure to fraud for almost 20 years as 'fact' and the insurers simply added this long-unsubstantiated loss estimate into consumer's premiums. When finally questioned about this huge loss of approximately 26 billion dollars over 2 decades, the industry admitted that it doesn't know where the figure came from. By then consumers had seen premiums go up and benefits slashed.***

http://www.fairassociation.ca/wp-content/uploads/2013/02/FAIR-Submission-to-Anti-Fraud-Task-Force-Status-Update-August-27-2012.pdf

Here is a link to the KPMG document final version released June 13, 2012. You will note the following issues with this report finalizing the 1.3 billion:

https://drive.google.com/file/d/1b0TfmfPhr9ZSorGG1J2uDzNm4Va7cS8n/view?usp=share_link

- Lack of Statistical Analysis: The report explicitly states that it does not rely on a statistically based estimate of auto insurance fraud. This admission is crucial, as it indicates that the figures presented ($770 million to $1.6 billion in fraud annually) are based on broad assumptions rather than empirical, statistically validated data. This undermines the reliability of the conclusions, especially since no comprehensive study of auto insurance fraud had been conducted in Ontario since 2001

- Reliance on opinions and estimates: the report uses various sources such as interviews, public opinion surveys, and closed claim studies. While these approaches provide insight into perceptions and potential fraud indicators, they are not concrete evidence of actual fraud occurring. Relying on such qualitative data introduces subjectivity into the conclusions. Public opinion surveys, for example, are inherently flawed when it comes to estimating fraud, as they reflect perception rather than factual occurrences

- The report references studies from the U.S. and Canada that are quite dated. For instance, the closed claims study referenced from Canada dates back to 2001, with the previous one in 1992. The lack of recent, localized studies severely limits the ability to accurately assess the current fraud environment in Ontario. Additionally, comparisons to the U.S. context might not be valid due to differences in regulatory and insurance frameworks

- The report notes that there is little hard evidence in terms of prosecutions or proven fraud cases, which makes it difficult to measure the actual extent of fraud. It mentions that many frauds go undetected or unproven, but without any concrete data on successful prosecutions or penalties for fraudulent claims, the extent of the issue remains speculative

- Fraud Estimates: The report estimates fraud in Ontario to vary wildly between $770 million and $1.6 billion per year, accounting for 9% to 18% of total premiums.

I will also attach a link to the IBC Pollara report about Auto Insurance Fraud Perceptions from what I can tell this was the first "perception" based report by IBC but not the last and most recently the FSRA has conducted a similar perception-based study that I will also

discuss, later on. This report was also a "valuable" report at the time promoting additional healthcare professional licensing.

https://drive.google.com/file/d/1x0rlXnKeJpL5wjpIvvLSWyoks03frtoW/view?usp=share_link

The 2013 Final Pollara report contains several methodological and interpretive issues that weaken its reliability as a basis for policy decisions.

1. Survey Design and Sampling Limitations:
- The survey was conducted via telephone interviews with only **1,000 Onta**rians, which raises concerns about the representativeness of the sample. Furthermore, certain regions such as Ontario North had very small sample sizes (n=70, with a ±11.7% margin of error), making the findings from these regions less reliable.
- The broad conclusions drawn from such limited data are problematic. The margin of error, particularly in regional breakdowns, undermines the precision of the findings.

2. Reliance on Public Perception:
- A significant portion of the report relies on the public's perception of fraud, rather than hard data or verified instances of fraud. For example, 83% of respondents believed fraud occurs frequently or occasionally, but these perceptions do not necessarily align with the actual prevalence of fraud. The report acknowledges that Ontarians are more concerned with opportunistic fraud (e.g., people prolonging treatments) than organized fraud (e.g., staged collisions or healthcare overbilling). Public perceptions can be influenced by media or anecdotal experiences and may not reflect objective realities.

3. Absence of Verified Fraud Data:
- The report does not provide any concrete data on actual fraud cases or detailed analysis of fraudulent activities. Instead, it focuses on public opinion, which can be misleading. For policy decisions, data-driven evidence of fraud prevalence, including how much fraudulent billing or organized fraud has actually been prosecuted or detected, would be more appropriate.

- The report's reference to the $1.3 billion annual fraud figure is based on industry estimates and has not been substantiated by independent audits or empirical studies. This figure remains contentious and unverifiable.

4. Leading Questions and Response Bias:
- Some survey questions seem designed to elicit specific responses. For example, asking participants whether they support initiatives such as seizing assets of those involved in fraud might lead to inflated support for punitive measures without participants fully understanding the issue or the scale of the problem. This introduces bias into the findings, making the results less reliable for policy recommendations.

5. Lack of Context on Existing Oversight and Regulation:
- The report does not adequately consider existing regulations or measures already in place to combat fraud. It suggests the need for tighter restrictions on clinic ownership and more government involvement, but it does not analyze the effectiveness of current systems, nor does it provide evidence that further restrictions would significantly reduce fraud.

In summary, if one were to have informed the government that the public is asking tighter oversight without informing people of the existence of healthcare colleges it would be quite the leading statement.

The report's heavy reliance on public perception, lack of verified fraud data, and small sample size makes it a poor foundation for policy decisions. It inflates the issue of fraud without providing concrete evidence, and its conclusions risk promoting policies that could unnecessarily burden healthcare professionals and consumers without addressing the root causes of fraud in a meaningful way.

FSRA licensing, PAF, and MIG were all built on the **false** narrative of 1.3 billion in auto insurance fraud by regulated healthcare professionals, and in this consultation document I will present how we need to refine and refocus 99% of the HSP licensing program and better utilize the human resources in market conduct that pertains to licensing to areas where it can provide better value for money.

Present Day and Historical Challenges Disenchanting Licensed Regulated Healthcare Professionals with HSP Licensing

1 - Taken from the 2021 FSRA Annual Report:

> *• Revenues were lower than budget as FSRA used its discretion to reduce the 2020-2021 assessments billed to our regulated sectors by $2.4 million in response to the COVID-19 pandemic. This unfavourable variance was partially offset by higher licensing fee revenue and higher interest income. page 43. -*
>
> Unfortunately for Health Service Providers although Health Service Providers were able to defer paying their regulatory fees, there was no reduction in the fees due and the end result is many small businesses had to struggle while larger industry players were seemingly given a discount by the regulator. **FSRA rebated $2.4 million in licensing fees to all regulated sectors except healthcare professionals during the 2020-2021 fiscal year in response to COVID-19.**

Healthcare professionals who were shut down through COVID were disenchanted by the FSRA who reduced licensing fees for insurers while health services provider licensing fees were not reduced. Insurers during COVID had significant profits while healthcare professionals were shutting down clinics. This treatment did not seem fair.

2- - Healthcare professionals are disappointed with FSRA licensing realizing then CEO, Mark White, at the 2023 FSRA Exchange, was ignorant that FSRA sets the fee maximums for health service providers, reflecting a concerning disconnect between FSRA senior leadership and the realities of the system.

- There is further disenchantment due to the CEO’s statement at that FSRA Exchange that Health Service Providers cannot voice concerns about insurer behaviours within the HSP Advisory Committee, limiting discussions to invoicing issues. This is particularly problematic from an ethical standpoint, as healthcare professionals have a duty to advocate for their patients' best interests, yet the FSRA seems to have no duty of care to listen and investigate concerns put forward by healthcare professionals regarding systemic issues.

- The restriction of the advisory committee's scope to invoice-related issues overlooks broader, legitimate concerns about how insurer behaviours impact patient care, leaving healthcare professionals feeling sidelined and unable to fulfil their ethical obligations.

- This narrow focus and dismissal of broader significant issues create frustration among healthcare providers, who see this as "legal double talk" that disregards their role as advocates for their patients who ensure the system stays sustainable.

3 – At the 2024 FSRA exchange Mark White finally acknowledged the FSRA role in setting fees for health service providers, but his answer sidestepped the real issue implying consumer following a car accident would be in a position to pay out of pocket and insurers would be willing to pay more than set maximums (this was also an ill-informed statement). These statements that are inconsistent with our lived experiences were hard to stomach and were dismissive, since we often see insurers deny specialty care that is more expensive than the SABS.

4- Healthcare professionals are disillusioned by the 2022 Market Conduct Report, which noted that 80% of professionals audited after answering a question about insurer-initiated examinations were given non-compliance letters for making a "False and Misleading Statement," despite the question being poorly worded.

When such a high percentage of respondents report misunderstanding the question, and auditors themselves apologize for issuing non-compliance letters, calling it "red tape," it reflects poorly on FSRA's ability to communicate effectively and fairly with health service providers.

This situation has further diminished trust, as healthcare professionals feel penalized for issues stemming from FSRA's unclear guidance rather than any real misconduct on their part.

5- The 2022 Market Conduct Report also noted that healthcare professionals were found non-compliant for failing to provide a change of address within 5 business days. However, healthcare professionals expressed frustration since FSRA's own AIR documents and forms still referenced FSCO and listed outdated addresses, such as 5160 Yonge Street, 16th floor.

FSRA is penalizing healthcare providers for something it has failed to do itself, update its' address, further eroding trust and highlighting inconsistencies in the system. Healthcare professionals are understandably disheartened by being held to standards that FSRA has not adhered to in its own documentation.

6 - In the same 2022 Market Conduct Report, FSRA emphasized significant non-compliance despite claiming extensive educational efforts. Referring to a single 30-minute session as "significant" was difficult for healthcare professionals to accept, as they are straightforward, common-sense individuals who expect more substantial support.

- FSRA had only conducted one 30-minute HSP webinar, attended by approximately 300 healthcare professionals, which left many feeling underserved. This was particularly frustrating for HSPs, who had previously raised concerns about structural issues with the HCAI system that led to submission errors—errors that were later classified as non-

compliance. Healthcare professionals felt unfairly blamed for problems rooted in the system itself.

7- - Healthcare professionals feel underserved by FSRA in their efforts to advocate for patients who are also auto insurance consumers. The bureaucratic approach of FSRA seems disconnected from the ethical concerns healthcare providers raise regarding insurer behaviour.

- Healthcare professionals frequently voice concerns to the FSRA about unethical practices, such as the behaviours found within auto insurer preferred provider networks that negatively impact patient care, access to benefits and harm the auto insurance healthcare system. Despite presenting news stories on the topic from reputable sources like the Globe and Mail, FSRA's Market Conduct does not addressed these issues.

Healthcare professionals often bring forth issues to be ignored of improper placement of patients by PPN providers in the MIG noting that a person with a minor injury, bounced out of the MIG, is entitled to up to $50,000 in medical-rehabilitation benefits, but not to optional benefits such as attendant care and housekeeping. In contrast, a person whose injury is not considered to be minor — i.e. a torn tendon — falls outside of the MIG and is therefore entitled to optional benefits (if purchased) and up to $50,000 in medrehab benefits. Those who are bounced from the MIG will receive less money than those claimants to whom the MIG does not apply. **Placing a claimant in the Minor Injury Guideline (MIG) saves insurers on long-term costs, especially on attendant care, as it restricts access to optional benefits like attendant care and housekeeping—even if this placement is primarily to meet adjuster demands rather than align with the claimant's actual needs.**

8- Healthcare professionals are especially frustrated by the impact of these preferred provider networks, which they view as harmful to consumer benefits, anti-competitive, and unethical. Despite raising these concerns repeatedly, despite reports in the newspaper of patient manipulation, FSRA has not taken meaningful action. Since ethical considerations fall outside of the legal framework, healthcare professionals often feel let down by FSRA's Market Conduct division when their concerns are overlooked.

9- Healthcare professionals were frustrated when none of the submitted questions at the 2024 FSRA Exchange from health service providers received a response from FSRA. Despite raising numerous questions on various important topics, FSRA ignored them all, deferring to an upcoming review. This was particularly disheartening as many of the questions posed had no connection to the review and could have been addressed independently, leaving healthcare professionals feeling disregarded and unheard. See link and scroll to the bottom to see the no submitted HSP questions were answered: https://www.fsrao.ca/fsra-events-calendar/2024-fsra-exchange-questions-and-answers

10- Feeling overlooked. When HCAI was introduced, insurance adjusters quickly raised concerns about reconciling invoices with treatment plans, and financial services responded promptly. A report from Canadian Underwriter, titled "**FSCO Introduces New HCAI Guidelines to Help Insurers Reconcile Health Care Invoices,**" notes how swiftly these changes were implemented. However, during the same period, healthcare professionals, myself included, were repeatedly requesting changes to the invoicing rules for treatment plans, which only allowed us to submit invoices once every 31 days. This made it difficult to run our practices consistently. Despite our calls and letters, we were told it wasn't a priority, and it took **three years** for this simple issue to be resolved with a minor language change to "once a month." This slow response starkly contrasts with the immediate action taken on insurer concerns.

https://www.canadianunderwriter.ca/insurance/fsco-introduces-new-hcai-guidelines-to-help-insurers-reconcile-health-care-invoices-1001505164/

From a business perspective, the "once every 31 days" rule for invoicing was highly impractical because businesses typically operate on a monthly billing cycle, which aligns with their cash flow needs and financial planning. This rule created unnecessary confusion, as invoices could not be sent on the same date each month, resulting in a constantly shifting invoicing schedule. It made tracking payments and managing finances more complex, adding administrative strain and potential delays in receiving payments.

For clinics like ours, that depend on steady cash flow to meet payroll, rent, and other expenses, this inconsistency was not just frustrating—it was demoralizing. A simple, common-sense request to change the rule to "once a month" would have streamlined operations and made it easier to plan and run our businesses effectively. Yet, despite numerous requests, this practical and easily implementable change was ignored for years. The lack of response to such a straightforward issue left healthcare professionals feeling unheard and undervalued. Financial Services just wasn't concerned with our red tape or our ability to serve our patients.

11- The 10-day rule to de-roster an employee from the HCAI system and its impracticalities under the Health Service Provider (HSP) licensing framework. The following is a breakdown of the problem:

1. **10-Day Rule**: Healthcare providers are required to remove an employee from their HCAI invoicing roster within 10 days of their departure. Once the provider is removed, no further invoices can be submitted under that provider's name, which creates several challenges in practice.
2. **Conflicting FSRA Guidance**: The FSRA in the 30 minute webinar has provided unclear and conflicting information. They suggest that providers can continue billing for up to six months after an employee is removed from the roster. However, providers report that this isn't possible in practice—once someone is removed from

the roster, the system (HCAI) does not allow them to submit invoices for that provider.

3. **Systemic Delays Beyond Providers' Control**: Various factors beyond healthcare providers' control delay invoice submission. Examples include:
   - **Work Benefits Delays**: If a patient or their spouse has work benefits, processing claims through these plans can take months. For patients with multiple plans, it can take over seven months to finalize benefits coordination, pushing invoice submission well past the six-month mark. When employees leave many invoices are not ready to submit for an auto insurer for many months.
   - **LAT Process**: Denied treatments often go through the License Appeal Tribunal (LAT) process, which can take years to resolve. By the time the treatment plan is approved, providers are asked to submit invoices for treatments provided years earlier, but they can't because the involved provider is no longer on the roster.
   - **Insurance Examination Delays**: Insurance examinations, which are required for some treatment approvals, can take months. If an employee leaves during this process, the clinic faces the same challenge of not being able to submit invoices, as the provider has been removed from the roster.

4. **Impossibility of Performance**: The system's conflicting rules make compliance nearly impossible. The HCAI system doesn't allow submission of a denied invoice, but if the employee is no longer on the roster due to the 10-day rule, providers are stuck in a catch-22. By the time the LAT decision or insurance examination is completed, or the work benefits statements are collected, and invoicing is allowed, the employee has been removed, and invoices can no longer be submitted.

This creates a regulatory dilemma that penalizes healthcare providers for situations beyond their control, making it nearly impossible for them to comply with the 10-day rule and the invoicing process simultaneously.

For years, healthcare professionals have been frustrated by the impracticalities of the 10-day rule under the Health Service Provider (HSP) licensing framework. Both the Financial Services Regulatory Authority (FSRA) and its predecessor, the Financial Services Commission of Ontario (FSCO), have failed to address this issue, despite repeated concerns from the healthcare community.

At the heart of this problem is the **conflict between compliance rules and real-world operational delays**. Under the current system, healthcare providers must remove an employee from their invoicing roster within 10 days of their departure. However, **various delays that are beyond providers' control**, such as processing work benefits or waiting for a License Appeal Tribunal (LAT) decision, often mean that invoices can't be submitted within this window. When these delays stretch into months or even years, the 10-day rule

effectively blocks providers from ever submitting these invoices, creating a **regulatory catch-22**.

This situation has caused **moral injury** among healthcare professionals, who are deeply committed to providing care for injured patients but are hamstrung by an administrative system that lacks common sense. Providers feel disrespected by a framework that **prioritizes rigid compliance over patient care**, and the failure of both FSRA and FSCO to address these concerns has only deepened this frustration.

Moreover, the excuse from FSRA auditors that "these are the rules" has been especially maddening for providers. It reflects an institutional unwillingness to adapt or apply **LEAN principles**—which focus on efficiency, waste reduction, and common-sense management—to the healthcare system.

By ignoring these long-standing concerns, FSRA has eroded trust among healthcare providers, further contributing to a lack of respect for the institution and worsening morale within the profession.

FSRA has never reached out to frontline healthcare professionals to ask how it could support auto insurance treatment or tried to understand how its regulations contribute to treatment challenges and rising costs.

12- The Financial Services Regulatory Authority of Ontario (FSRA) has been highly critical of healthcare professionals over compliance issues, but the point of licensing is invoice accuracy. These criticisms are based on technicalities that have no bearing on the quality of care provided.

For example, many professionals have faced scrutiny for not providing timely notification of an address change. Meanwhile, FSRA continues to issue receipts under its outdated name, Financial Services Commission of Ontario (FSCO), an error that persists years after FSRA's establishment. The irony is evident: while healthcare professionals are held to stringent standards for administrative details, FSRA fails to meet its own.

Despite this, FSRA regularly sends bulletins claiming they are exceeding expectations, seemingly disconnected from the real challenges faced by healthcare professionals.

The most critical issue in Health Service Provider (HSP) licensing is invoice accuracy, but the question remains: has FSRA uncovered any fraud?

When timelines for reporting address changes or de-rostering professionals are unreasonably short, or compliance rules are convoluted and poorly worded, non-compliance is inevitable. But missing compliance isn't invoice fraud—so if fraud isn't the issue, it's time to question the value of these licensing requirements.

HSP Licensing in 2024

1- The current HSP licensing system costs FSRA and ultimately consumers more than it generates in fees from healthcare service providers. The total loss to the FSRA and insurance industry is not clearly disclosed in the FSRA financial statements.

2- The current HSP system was not requested by healthcare professional colleges and associations, they actively voiced concerns against this system and refer to it as redundant as noted in the consultation document

3- HSP licensing involves FSRA staff monitoring healthcare college websites to review completed investigations into healthcare professionals. However, in all cases where FSRA's Market Conduct division followed up on these investigations, they did not uncover any findings beyond what the healthcare colleges had already concluded.

This practice, as outlined in the 2022-2024 Health Service Provider Market Conduct Compliance Report, seems like unnecessary duplication of effort. FSRA is using resources to recheck work that has already been thoroughly investigated and resolved by the healthcare colleges, which are the primary regulatory bodies for these professionals. This redundancy adds no new insights or value, making it a poor use of resources and not good value for money.

On a positive note, it does show that healthcare colleges are effectively fulfilling their role in protecting the public. This raises the question of whether HSP licensing, as it currently operates, is truly needed.

https://www.fsrao.ca/industry/health-service-providers/publications/2022-2024-health-service-provider-market-conduct-compliance-report

4- Monetary penalties resulting from HSP licensing audits have been imposed in slightly more than 0% of all audits.

5- FSRA's market conduct reports do not indicate instances of invoice fraud among health service providers. Instead, compliance issues mainly arise from misunderstandings related to coding, missed deadlines for submitting Accident Insurance Reporting (AIR) paperwork, notifying address changes within five business days, or updating professional rosters within 10 days.

For example: The 2022- 2024 market conduct highlighted an issue noted by healthcare professionals, the language used in AIR forms by FSRA did not align with their daily terminology. The language used by the FSRA was not used in the SABs either so in the 2022 audit, this discrepancy led to confusion, with over **80%** of audited providers misunderstanding a question related to insurance-initiated exams since the question could

have two meanings. All these providers were deemed non-compliant despite auditors themselves noting that the wording in the AIR form was unclear and inconsistent. A LEAN operation would have removed the question as a basis to initiate an audit.

A Review of HSP enforcement Actions over the last few years notes significant increases in license suspensions and revocations due health service providers refusing to renew the AIR or pay licensing fees.

HSP ENFORCEMENT ACTIONS				
Year	Warning Letters	Licence Suspensions	Administrative Monetary Penalties	Licence Revocations
2019-2020	0	0	1	0
2020-2021	15	0	0	0
2021-2022	36	60	0	0
2022-2023	758	106	0	1

The Issues with HSP licensing are coming home to roost in 2022-2023 regarding the issuance of the 758 warning letters. Here's my take on the situation:

1. AIR non submission: **The fact that 607 of the warning letters were issued because providers did not submit their AIRs** speaks to a broader issue with the regulatory framework and the administrative burden on providers. If any if not all of these 607 providers are leaving the system, that could account for **12%** of providers, it signals that the compliance process is either too burdensome or misaligned with the realities of running healthcare practices. Warning letters for late submissions seems like an overly harsh penalty, especially given the ongoing difficulties faced by health service providers during and post-pandemic. Yet it does look like enforcement is working until we look at what is being enforced. Timelines and arbitrary rules created by the FSRA are being enforced yet there is no invoice fraud uncovered by the FSRA.

2. Misunderstanding in Annual Information Return (AIR): **The fact that 82 of the 758 warning letters were issued because of a misinterpretation of a question in the AIR is troubling.** It indicates that the question was either poorly worded or unclear, leading to confusion among providers. It seems unreasonable to penalize clinics, especially those that provide legitimate services but misunderstood the question, with formal warnings. This appears to be an administrative flaw rather than a compliance issue on the part of the clinics. It would have been more efficient for the FSRA after the first ten audits uncovered the misunderstanding, to clarify the question and give clinics a chance to correct their answers rather than going through with unnecessary audits then issuing warning letters that carry negative connotations.

3. Warning Letters from Site and Compliance Reviews: The 37 on-site reviews and 80 compliance reviews resulting in 69, but again, if none of these letters are related to fraud, the usefulness of issuing formal warnings is questionable.

Moral Injury of Healthcare Professionals: These are tough times for healthcare professionals today, physiotherapists and chiropractors are primary care providers and even though none of these warning letters are tied to fraud, they carry a stigma. Clinics receiving such letters may be unfairly perceived as non-compliant or problematic, which can harm their reputation. In fact, the FSRA has often touted these warning letters as failures of healthcare professionals to "follow the law" here is FSRA's own bulletin that further perpetuates this narrative. https://myemail.constantcontact.com/Taking-steps-to-ensure-health-service-providers-comply-with-the-law---Mesures-prises-pour-garantir-que-les-fournisseurs-de-servi.html?soid=1132656455417&aid=Qz1OF6CLqdI

Providers are leaving the system linked to both the administrative burden and the perception that financial regulators are overly punitive and not concerned with our patient care focus.

Inefficiencies in Ontario's Accident Benefits Framework: unnecessary regulatory, delays and system duplication.

1- Unlike in other regions, Ontario has a redundant extra layer of oversight through FSRA Health Service Provider (HSP) licensing, even though healthcare professionals are already regulated by their colleges. This redundancy drives up administrative costs without improving care or fraud prevention, the sector of mainly regulated health professional owned clinics is highly ethical, with invoice fraud – the only rationale for the HSP system -being virtually nonexistent.

2- We are the only jurisdiction in the world with a dedicated HCAI in Ontario even the WSIB has chosen to rely on a private carrier in Telus do provide the same function.

3- Moreover, Ontario's ineffective use of insurance companies' closed Preferred Provider Networks (PPNs) adds another expensive layer of medical assessments, which could be handled more efficiently within the existing healthcare system. These inefficiencies ultimately inflate insurance premiums, burdening consumers without delivering better results.

4- It's highly confrontational both within the treatment system between clinic and adjusters and within a LAT system that has systemic design issues and fails to meet the needs of consumers trying to access treatment in a timely manner

5- It tries to recreate to many aspects of existing more efficient systems such as invoicing, licensing, and second and third opinions more expensively within the financial services framework. Every program that exists within auto insurance is an expensive less effective replica of what is already working in the regulated healthcare framework. Financial services not appreciating the healthcare framework is doing a bad job in creating treatment frameworks, licensing frameworks, second opinion frameworks, and invoicing programs poorly.

6- In the end the auto insurance consumer and the healthcare professional must pay for all this inefficiency and duplication

HSP Licensing looking at the cost of red tape to our economy:

Money and time spent on red tape is taken away from economic growth

- The direct fees collected by FSRA from health service providers for HSP licensing from 2014 to 2024 amount to approximately **$34 million.** This figure does not account for the indirect costs of compliance, which are significantly higher.
- Indirect costs include the time and resources spent on meeting FSRA's regulatory requirements, such as completing Annual Information Returns (AIRs) and preparing for audits. It is estimated that each clinic incurs around $5,000 annually to comply, resulting in a total industry-wide cost of $24.5 million per year (based on an estimated 4,900 clinics). Since the inception of HSP licensing, the total cost to the industry is estimated at **$245 million**, placing a substantial financial burden on healthcare providers.
- Since the HSP framework mandates the use of the HCAI Portal for invoicing. The administrative burden within the current invoicing system is due to complicated and repetitive forms, as well as the significant burden of managing work benefits as the primary payer. These requirements lead to staffing costs of approximately $25,000 per clinic per year, amounting to an industry-wide cost of $123 million annually. However, with anticipated legislation aimed at removing work benefits as the primary payer nearing implementation, this burden could be significantly reduced for all stakeholders. Since the inception of HSP licensing, the total cost to the industry is estimated at **$1.2 billion**, placing a substantial financial burden on healthcare providers.

These costs to the economy of over **1.4 billion dollars** since inception are conservative estimates, yet they are more than merely financial; they also represent a significant diversion of resources away from patient care.

For example:

The time spent by clinic staff on compliance tasks—such as preparing for audits and submitting detailed documentation—could have been spent on providing care to patients.

The time spent on audits alone has resulted in the loss of millions of patient visits in Ontario since the previous government introduced the licensing framework.

This diversion of resources negatively impacts patient care and exacerbates the challenges faced by Ontario's healthcare system.

The path forward should focus on **data-driven** decisions rather than speculative perceptions.

Working together, we can build a more efficient and effective system that benefits all stakeholders—auto insurance consumers, patients, healthcare providers, and insurers—based on real-world evidence and actual patient needs.

Every healthcare professional understands and supports the need for oversight and regulation to ensure accountability and quality of care because they are already regulated by healthcare colleges, yet HSP licensing is causing moral injury to the regulated healthcare professionals.

However, having two oversight bodies for businesses controlled by regulated healthcare professionals does not provide a stronger deterrent than having just one. In fact, increasing the number of oversight bodies simply adds more red tape and administrative burden.

Applying LEAN principles, we know additional layers of regulation lead to inefficiencies, creates confusion, and diverts valuable resources away from patient care. For optimal value for money, it's essential to streamline oversight to one regulatory body per health service provider organization either FSRA HSP licensing, or the Health Regulatory College, which can maintain standards without imposing unnecessary complexity on healthcare professionals who are already committed to following established ethical guidelines.

Is HSP Licensing in the current form is it “Fit for Purpose”?

As noted within the Consultation:

1. The current requirement for HSPs to obtain a licence in order to bill electronically does not appear to be achieving the intended objectives of controlling costs and ensuring effective provisions of benefits by reducing fraud.
   TRUE

2. HSP stakeholders have raised concerns that FSRA’s regulatory approach is redundant with oversight of Ontario’s regulated health professionals by the RHCs.
   TRUE

3. Administrative requirements should be reduced, including minimizing unnecessary administrative tasks and paperwork to ease the regulatory burden on HSPs.
   TRUE

4. Fraud and abuse in the auto insurance system, which HSP licensing was intended to manage, is still perceived as a major issue by the public and stakeholders despite the implementation of HSP licensing and conduct oversight.
   MISLEADING

Are the Goals of HSP licensing being met?

As highlighted on page six of the HSP consultation document, a purpose of an HSP license is to:

> *facilitate direct payments from auto insurers to healthcare providers for services rendered to SABS consumers.*

Real-world experience and historical institutional knowledge reveal that **HSP licensing has not improved consistency or efficiency of direct payments.**

Today, insurers continue, in many cases, to send payments for interest and care directly to their insured clients as frequently as before licensing. Healthcare professionals were already receiving direct payments from insurers prior to the introduction of the HSP licensing requirement.

Additionally, professionals had access to HCAI before 2010 well before the introduction of HSP licensing in 2014. HSP licensing was not a requirement in the past to use HCAI. Both HCAI and HSP licensing were imposed on healthcare professionals by the previous government, a move that increased regulatory burden, cost and red tape.

HCAI increased invoice complexity for healthcare providers. While HSP licensing made everything that much more cumbersome.

This consultation is an opportunity to reassess the licensing framework and explore more effective ways to streamline processes, reduce administrative burdens, and ensure that healthcare professionals can focus on providing the best possible care to patients, without unnecessary regulatory hurdles thus improving the benefits for consumers.

Two Regulators, Two Different Approaches

Regulated Healthcare Professionals have found the increased administrative burden of a HSP rules-based reporting system at odds with the more robust ethical based framework within the Regulated Healthcare College Framework. Also of note is the lack of front-line insights the financial services had in creating compliance-based rules.

The challenge lies in the conflict between two fundamentally different regulatory approaches. Healthcare professionals are regulated by their respective Colleges, which operate within an ethical, patient-centred framework. This framework emphasizes professional judgment, context-sensitive decision-making, and a deep commitment to patient care. In contrast, the HSP licensing framework, rooted in the financial services model, is compliance-based, focusing on rigid protocols and procedural adherence.

The introduction of a second layer of oversight through HSP licensing has led to inefficiencies and frustration for healthcare providers who already operate under the stringent ethical and professional oversight of their Colleges. The compliance-based requirements of the HSP licensing framework, which are binary and rules-driven, conflict with the flexible, context-aware nature of healthcare delivery. As a result, healthcare professionals find themselves navigating two competing systems of oversight, which not only duplicates regulatory processes but also detracts from patient care.

Why the Consumer is Not Best Served by Dual Regulation:

The insurance consumer is not better served by this dual regulatory approach. Healthcare professionals have been successfully regulated by their Colleges for generations, with a proven track record of ensuring high standards of care, ethical conduct, and patient safety. The role of these Colleges is to protect the public, and the data I will present demonstrates that healthcare Colleges are effectively fulfilling this role. Adding a second regulator with a compliance-driven model, designed for financial services rather than healthcare, introduces unnecessary complexity and administrative burden.

This **dual oversight does not enhance public protection** but rather detracts from the core mission of healthcare providers: delivering timely, effective, and patient-centred care. Instead of improving the system, this added layer of regulation has created inefficiencies that undermine the very goals it was meant to achieve—namely, the efficient and transparent delivery of care.

The added regulation is then paid for by the auto insurance consumer.

Trust in the Healthcare College Framework:

The key to a more efficient system lies in recognizing and trusting that the existing current healthcare College framework is doing its job as noted in every other framework such as OHIP, WSIB and Private Fee for Service payers. (It’s also noted in the 2022-2024 FSRA Market Conduct Report.)

The Colleges of all regulated healthcare professionals in Ontario have consistently upheld rigorous standards, ensuring that healthcare providers are accountable, competent, and ethical. These institutions are well-equipped to handle the complexities of healthcare regulation because they are built on principles that prioritize patient outcomes and public safety.

The data shows that much less than one percent of audits result in administrative monetary penalties, and invoicing fraud is virtually non-existent. As former FSRA CEO Mark White stated at the 2024 FSRA Exchange Fireside chat, "you will never completely eliminate fraud." Yet, HSP data makes it clear that healthcare service provider fraud is practically non-existent—a testament to the effectiveness of healthcare colleges in achieving what FSRA's rules-based HSP framework has not. Perhaps it's time for FSRA to step back and let healthcare professionals focus on patient care without redundant oversight.

Regulated healthcare professionals are very focused on maintaining their healthcare college registration in good standing by ensuring proper invoicing and ethical patient care. Logically we believe that being the point of HSP licensing (invoice accuracy) should be enough. However, they often struggle to keep up with the red tape and arbitrary compliance deadlines imposed by FSRA, which are not correlated or causal to invoice fraud.

Therefore, rather than duplicating regulatory efforts, the government should focus on enhancing the efficiency and trust in the already robust systems in place. The healthcare sector operates best when professionals are allowed to apply their judgment and skills without being encumbered by redundant oversight. For clinics owned by regulated healthcare professionals, the regulatory colleges have shown their value.

HSP licensing was originally intended to uncover invoice fraud. Now, after 10 years and over a billion dollars in lost economic productivity, we have to ask financial services: **where are the individuals prosecuted or held accountable?** If any fraud was uncovered, who identified it first—the FSRA or the healthcare colleges? (Answer – it was the healthcare college).

Is HSP licensing money well spent at the FSRA, or should they start focusing on and licensing tow trucks and body shops like other provinces do?

Those of us with a long memory will recall the IBC and various newspapers reporting $1.3 billion in auto insurance fraud. However, thanks to HCAI, we now know that the total annual invoicing from health service providers is no more than $645 million. Ironically, **the one good thing that has come out of both HCAI and HSP licensing is the data proving we don't actually need either system.** HSP licensing was a knee jerk reaction to perception rather not fact.

By trusting in the existing Healthcare College-based regulatory framework, we can streamline processes and refocus HSP licensing on areas where it can better serve the consumer such as areas where ownership is not overseen by a regulated healthcare professional which would be a more focused use of FSRA resources, and we could begin the oversight of know problem areas such as Tow Truck operators and Body Shops which has been proven beneficial in other jurisdictions and an Auditor General recommendation.

We should reduce unnecessary administrative burdens, bring value and cost savings to the consumer, and ensure that the public receives the best possible care—without the inefficiencies created when Regulated Healthcare Professionals who open clinics to practice professions they love are subjected to **dual** regulatory oversight, and those who open businesses without ethical regulations only have **one** oversight body.

Response to the Following Statement In the Consultation

> *Fraud and abuse in the auto insurance system, which HSP licensing was intended to manage, is still perceived as a major issue by the public and stakeholders despite the implementation of HSP licensing and conduct oversight.*

The above statement points to ongoing concerns from the public and stakeholders. However, it's important to examine the basis of these perceptions. It is another study of 1000 people. Such a study has very little relevance to the perceptions of an entire province.

The basis for the above statement is seen in more recent a poll commissioned by FSRA, which was surprisingly similar to the Pollara Poll in 2012 where the large majority of respondents, had ***never experienced an auto insurance claim***, were asked about their concerns regarding potential fraud.

The fact that 83% of respondents in the FSRA poll have never been victims of auto insurance fraud, and over 25% (258 out of 1,027) **didn't even have auto insurance**, shows a clear disconnect between the data and the conclusions being drawn.

We should never base auto insurance policy decisions on fear-based assumptions from people without real experience and are not even auto insurance policyholders. The actual FSRA data shows healthcare provider fraud is virtually non-existent, it's clear that these speculative surveys are misleading and should not be used to justify continued redundant regulatory frameworks.

Here is a link to the FSRA post online : https://www.fsrao.ca/announcements/majority-ontarians-believe-auto-insurance-fraud-prevalent-province:~:text=In%20a%20recent%20poll%20commissioned,victim%20of%20auto%20insurance%20fraud.

Here again is a link to the Pollara Poll for comparison:
https://drive.google.com/file/d/1x0rlXnKeJpL5wjpIvvLSWyoks03frtoW/view?usp=share_link

This FSRA poll, entitled "A Majority of Ontarians Believe Auto Insurance Fraud is Prevalent in the Province," asked participants to **imagine** what their concerns would be if they were in an auto accident. Naturally, those with no direct experience speculated based on fear, leading to perceptions that fraud was a significant issue. This type of speculative data can inadvertently promote concerns that are not necessarily grounded in actual experience.

The FSRA's own data, along with reports from regulated healthcare providers, show that healthcare provider fraud is virtually non-existent. Thus, while the perception of fraud remains high, the actual incidence does not support the continuation of this narrative.

This consultation is a great opportunity here to focus on solutions **grounded in facts not perceptions.** I acknowledge that I have my own biases and am trying very hard to objectively and ethically present facts in an ethical manner for the benefit of patients, and the auto insurance system as a whole; as a healthcare Professional it is my duty to the system to do so. And in the future **I hope the FSRA will conduct a survey of <u>actual</u> accident victims who have navigated the auto insurance system such a study would allow us to focus on addressing genuine inefficiencies rather than assumptions or fear-based perceptions. Such a study would truly benefit LEAN improvements.**

Removing Health Service Provider Licensing for Providers who are already regulated by Healthcare Colleges is A GREAT IDEA!

The Health Service Provider (HSP) licensing consultation offers a valuable opportunity for improvement and refinement. Initially introduced in 2014, the framework added an administrative layer for healthcare professionals already governed by their respective healthcare Colleges.

In hindsight, it is clear that attempting to replicate the oversight responsibilities of **27 existing healthcare Colleges within a single entity, FSRA,** rather than focusing exclusively on unregulated entities, was overly ambitious and wrong. This broad approach has diluted the framework's effectiveness in enhancing public protection. As the saying goes, **"In trying to do everything, you often end up accomplishing nothing except wasting time and resources."**

Consequently, the system has placed substantial administrative and financial burdens on the public, the auto insurance consumer, regulated healthcare providers, and FSRA itself.

Revisiting and refining the framework presents an opportunity to streamline processes, reduce redundancies, and create a more efficient, targeted regulatory approach that aligns better with its intended purpose and serves all stakeholders effectively. It also allows FSRA to address tow trucks and body shops without having to hire new staff. An effective redeployment of human resources. The need for licensing of these entities was outlined in several Auditor General Reports and FSRA auditors would be equipped at dealing with these entities within a rules-based framework. This was recently noted in 2022 by the Ontario General and the C.D. Howe Institute, yet the auditor general has noted this for over a decade.

By redeploying FSRA resources, we can enhance regulatory oversight in areas where healthcare professionals have voiced concerns for years.

FSRA licensing should focus on what professionals colloquially refer to as "businessman" owned healthcare practices, (practices that are not already controlled by regulated healthcare professionals), as well as direct oversight towards sectors that currently lack sufficient regulation, such as tow truck operators and body shops—areas flagged by the Auditor General for over a decade.

This shift in focus would not only improve HSP licensing but by avoiding redundant regulation over regulated healthcare professional owned clinics, it allows FSRA to make a

more meaningful impact, ensuring that resources are used efficiently and where they provide the greatest value. By refining FSRA's role, we can develop a more effective system that minimizes duplication, better serves the public, and supports healthcare professionals and consumers alike.

Redundancy

Ontario Regulated Healthcare Professionals are already rigorously regulated by their professional colleges, such as the College of Physiotherapists and the College of Chiropractors, which uphold high standards for conduct and competence. FSRA's additional licensing layer duplicates this oversight, adding unnecessary bureaucracy and creating confusion with overlapping regulations for businesses controlled by these healthcare professionals.

Ontario's situation is uniquely challenging, as it is the only jurisdiction in the world that imposes additional HSP licensing for the auto insurance sector. This extra layer of regulation, not required under frameworks like OHIP or WSIB, leads to excessive administrative burdens, professional burnout, and even the loss of healthcare providers. Worse, the costs of duplicating oversight are passed along to consumers, driving up prices in the auto insurance sector. Removing HSP licensing would streamline oversight, reduce costs, and help retain skilled professionals in the province.

Being an outlier in this situation is not a good thing, and Ontario is indeed an outlier.

Eliminating HSP licensing for regulated healthcare professionals would not only reduce costs for all stakeholders but also allow government resources to be efficiently redirected to areas that genuinely require regulation. "If one police officer tells you to put your hands in the air, does having a second officer giving the same command really make a difference?" In fact, having two authorities issuing the same command can create confusion and even conflict, as it's unclear who is truly in charge. This duplication of oversight currently leads to inconsistent interpretations, undermining the clarity and effectiveness of the regulatory process. Streamlining to a single, trusted authority is essential for maintaining clear, efficient, and effective oversight.

Administrative and Financial Burdens

The HSP licensing framework creates a significant administrative and financial burden on regulated healthcare providers who manage their own practices. Unlike healthcare professionals, clinic owners without a healthcare background face less red tape, dealing solely with a single agency, the FSRA. This disparity hampers the ability of qualified professionals to focus on delivering top-notch care.

Initially introduced by the FSCO due to insurance industry lobbying to the previous government, this framework costs more to administer than the value it generates or the behaviours it aims to prevent. Since healthcare professionals operating clinics are already effectively regulated by their respective healthcare colleges, which provide sufficient oversight, there is no evidence that the HSP licensing framework delivers value for money or makes a meaningful impact in this context. This is in contrast to other FSRA licensing frameworks, such as for mortgage brokers, where FSRA is the sole regulator, and its effectiveness is clearer.

Furthermore, the systemic administrative costs imposed by auto insurance-specific systems—such as HSP licensing, the insurance-initiated exam process, and the Health Claims for Auto Insurance (HCAI) system—could be replaced with more common-sense, cost-effective alternatives. Expensive frameworks like HSP licensing are redundant to the healthcare colleges. The closed preferred provider networks used for insurance examinations, can be replaced with readily available and cheaper system of what is essentially a second opinion. And HCAI can be replaced with the Telus portal that WSIB uses. These "subpar adaptations" in auto insurance contribute to unnecessary overhead which ultimately increases premiums uncontrollably.

Streamlining these processes with existing, more affordable solutions would alleviate the financial burden on both the system and consumers.

Systemic costs are universally passed on to consumers, with insurance companies applying their typical markup. Since these are global costs, all insurers add a percentage markup to administrative expenses, leading to higher net profits. For example, a 5% markup on $1 million in admin costs results in $50,000, but on $1 billion, it jumps to $50 million. While the percentage stays the same, both insurer profits and consumer costs rise substantially. This system increases costs for auto insurance consumers and turns red tape into a profit centre for insurers.

Lack of Demonstrated Benefits of HSP Licensing in Fraud Prevention

There have been no observable benefits due to HSP licensing. There have been many observable **harms**—skyrocketing administrative costs, excessive red tape, and valuable resources drained away from patient care. This framework has burdened regulated healthcare providers with bureaucratic hurdles that serve no real purpose, stifling their ability to operate effectively. Instead of protecting or improving healthcare quality, HSP licensing has become an obstacle, enriching insurers and bloating regulatory bodies staffing needs at the direct expense of professionals and the patients they are committed to serving.

Of the approximately 1,950 audits conducted up to March 2023, less than 1% resulted in penalties, most of which were for minor administrative issues rather than fraudulent behaviour. This outcome raises questions about the necessity of the framework in achieving its intended goals.

The 2022 FSRA HSP Market Conduct Report identified issues such as missing electronic signatures and delayed registry updates, but healthcare professionals noted that these challenges often stem from the complexities of compliance and HCAI electronic portal issues rather than intentional non-compliance. For instance, meeting the ten-day timeframe for registry updates is difficult, given that invoicing processes can extend for several months. Similarly, unsigned electronic invoices represent secretarial oversights that do not compromise the quality of care or invoicing accuracy, and these issues also stemmed from invoice complexity within HCAI. (of note the HCAI consultation is coincidentally and finally looking into the suggestion of making the signature field mandatory which would completely eliminate this issue)

By refocusing and redeploying HSP licensing efforts we can be as effective and ensure that resources are used efficiently without compromising the sustainability of the auto insurance product and delivery of care.

Detrimental Impact on Healthcare Providers and Patients

The HSP licensing system imposes barriers that limit patient access to rehabilitation services, as providers increasingly opt out of the framework. As reported in the October 13, 2022 Market Conduct Activities Report (page 12), many businesses chose not to renew their licenses, citing that they "no longer deal with Statutory Accident Benefits Schedule (SABS) claimants." This statement is only those contacted for late AIR payments and does not account for the broader number of providers who, despite paying their fees, have opted out due to the burdensome requirements.

This reduction in licensed providers impacts patient care and is only beginning which will negatively impact all areas of our healthcare system, prolonging recovery times and increasing the risk of long-term disability and dependence on public healthcare and social services when local providers are unavailable.

Ontario is nearing a tipping point where inefficient market oversight could lead to a generational miscalculation in healthcare access. It is crucial that we proactively address this issue now through this consultation, an opportunity for the Ministry of Finance to be forward-thinking and prevent potentially irreversible consequences which were started during the previous government of Ontario.

Economic Benefits Lost

Regulatory efficiency is a crucial driver of economic growth. Reducing red tape, particularly by eliminating redundancies, can energize the province's economic momentum. By redeploying the time and money currently lost to regulatory burdens, both at the FSRA and Healthcare Professionals, we can shift the focus from duplicate compliance to innovation and productivity, fueling economic progress.

Rehabilitation clinics are significant contributors to local economies, and among the over 4,900 licensed clinics across Ontario, many face duplicate regulation through FSRA, which has shown no added benefit to them or consumers. Redirecting the resources spent on this redundant oversight back into the economy aligns with sound economic theory.

By streamlining compliance so that each clinic reports to their particular regulatory agency, we can reduce administrative overhead and allow businesses to invest more in patient care, technology, and job creation. The result is not merely a numerical increase in GDP but a renewed vitality that permeates the entire province, benefiting every community and citizen. Achieving a simpler, more innovative, and stronger economy isn't just a vision—it's a policy decision within our reach.

Healthcare Professionals Colleges are Already Effective Fraud Deterrents

Healthcare professionals, governed by the ethical frameworks of their professions and overseen by their regulatory colleges, act as the primary deterrent against fraud. These professionals are dedicated to patient care and are not inclined toward fraudulent behaviour. The oversight provided by regulatory colleges already covers all aspects of professional conduct, including the monitoring of potentially fraudulent activities.

With less than 1% of FSRA audits resulting in penalties, it is clear that healthcare providers maintain a high level of compliance. While the intention to prevent fraud is understandable, the FSRA's HSP oversight appears to be addressing a minimal issue, imposing unnecessary administrative burdens on healthcare providers in the process with a very heavy handed and red tape heavy approach.

To Align with Best Practices

No other jurisdiction **worldwide** imposes an additional licensing framework on regulated healthcare professionals for treating auto insurance patients. In other healthcare systems, such as the Ontario Health Insurance Plan (OHIP) and the Workplace Safety and Insurance Board (WSIB), healthcare providers are solely regulated by their professional colleges, which have proven effective in maintaining high standards of care and compliance.

Aligning with best practices seen in other jurisdictions, removing the HSP licensing framework would eliminate unnecessary duplication and reduce administrative burdens on healthcare providers, all while maintaining the high level of oversight already provided by healthcare colleges. This approach ensures that resources are used efficiently, aligning Ontario with global standards and practices in healthcare regulation. The rigid compliance requirements do not correlate with fraud prevention for those regulated healthcare professionals who control clinical practices.

The previous government made a misstep by attempting to reinvent and poorly adapt parts of 27 existing regulatory Colleges into the auto insurance framework. This "Made in Ontario" solution was the brainchild of someone who now writes comedy, but their legacy at Financial services is more of a tragedy. HSP licensing in its current form is a classic case of bureaucratic overreach. If we don't undo this redundancy and other errors like it, we can expect premiums to keep rising.

A Suggestion: Improving Billing Practices Through Professional Ownership

While this may not have been on the radar of the original FSRA drafters of the consultation document, I will refer to the statement on page 8, where FSRA welcomes stakeholder ideas, as an opportunity to suggest an improvement: enhancing billing practices through professional ownership structures.

To ensure appropriate billing practices among Health Service Providers (HSPs), it is essential to scrutinize the ownership structure of healthcare institutions. When clinics are owned by non-regulated individuals or entities, the integrity of billing practices in the opinion of regulated healthcare professionals can be compromised. In fact, our Colleges warn us of monitoring the invoicing submissions using our names and this is always a concern when the owner is an unregulated individual for us.

Drawing on successful models from other healthcare sectors, such as Ontario’s pharmacy ownership model, a ‘closed garden’ approach may be recommended for HCAI access.

The 'Closed Garden' Ownership Model

Under this model, similar to Ontario’s pharmacies—where ownership is restricted to pharmacists or corporations where the majority of directors are pharmacists—rehabilitation clinics would be required to have at least 50% ownership by regulated healthcare professionals, such as physiotherapists or chiropractors. This approach would strengthen accountability and billing integrity, ensuring that those who operate these clinics are invested in maintaining the highest professional and ethical standards.

Stakeholder-Initiated Questions for Further Consideration in the HSP Framework Review

Does the current HSP licensing system provide clear benefits to consumers and effectively support consumer's healthcare providers in delivering care?

Answer: In its current form, the HSP licensing system appears to duplicate the oversight already provided by professional healthcare colleges, which are well-equipped to regulate healthcare professionals through established ethical frameworks. This duplication creates unnecessary administrative and financial burdens for regulated healthcare providers who operate and manage clinics and healthcare businesses.

To improve the system, HSP licensing should be refined to focus specifically on non-regulated entities that currently lack sufficient oversight, such as businesses not managed by regulated healthcare professionals. By shifting focus, FSRA could ensure that resources are effectively utilized in areas where there is a greater need for monitoring and compliance.

A more targeted approach would respect the existing regulatory framework already in place for healthcare professionals, reduce unnecessary burdens, and improve efficiency for clinics, ultimately benefiting consumers by allowing providers to focus on delivering high-quality care without redundant administrative hurdles.

What is the necessity and value of Health Service Provider (HSP) Licensing from the perspective of an already Regulated Healthcare Professional?

Answer: From the perspective of regulated healthcare professionals, the current HSP licensing system feels redundant and burdensome. These professionals are already held to high standards and rigorous oversight through their healthcare colleges, which ensure compliance, ethical conduct, and fraud prevention. The additional layer of HSP licensing duplicates this oversight, leading many professionals to feel penalized for their extensive training and commitment to their profession. It adds extra costs and administrative tasks that they believe are unnecessary, considering their existing regulation.

However, a more focused HSP licensing regime could bring multiple positive benefits. By narrowing its scope to non-regulated entities or businesses not controlled by healthcare

professionals, FSRA could target areas that genuinely need oversight without imposing additional burdens on those already regulated. This approach based in common sense would prevent regulated healthcare professionals from being unfairly penalized or overburdened, maintaining their focus on providing patient care rather than navigating duplicate regulatory requirements.

How can the FSRA enhance the value of HSP licensing to ensure it delivers the most efficient and effective use of resources for healthcare professionals and consumers?

Answer: The FSRA must avoid duplicating work done by other healthcare regulator government agencies just like it does with the OSFI. To deliver value for money while effectively safeguarding consumers HSP licensing efforts should be on areas without existing oversight, such as businesses owned by non-regulated entities, tow truck operators and body shops. Tow trucks and Body Shops have been highlighted for years as requiring regulation, and directing resources there would address known risks within the auto insurance sector. Healthcare regulators already oversee all professional and business aspects of the regulated healthcare professional making HSP licensing harmful to regulated professionals and the economy.

Additionally, the FSRA can provide value by examining insurer behaviour and its impact on consumers from both an ethical healthcare perspective and a holistic view of the healthcare market which is a significant gap in insurer regulation and consumer protection. Understanding how insurers interact with consumers and regulated healthcare providers and ensuring they do not shift costs to other frameworks, such as the Ontario Health Insurance Plan (OHIP) would help protect the integrity of the healthcare system and prevent undue burdens on other sectors.

FSRA must refine its focus to regulate areas of genuine need and high impact. This would ensure that resources are used efficiently, reducing duplication and administrative burdens for healthcare providers, and ultimately benefiting consumers through a more streamlined and effective regulatory approach.

Does the current HSP licensing framework effectively support consumer access to care and operate in a lean, efficient manner that maximizes value?

Answer: Many regulated healthcare professionals who provide services to accident victims report that the additional administrative burdens imposed by the framework have the opposite effect. (As noted earlier in this document many providers choose to

discontinue offering services in the framework). Clinics, particularly those owned and managed by regulated professionals, face increased costs and compliance requirements that divert resources away from patient care and rehabilitation services. As noted by the FSRA they are leaving the sector.

A more targeted licensing approach will improve patient access by focusing HSP licensing only on non-regulated entities, allowing regulated clinics to operate under the oversight of their professional colleges. This would streamline the regulatory process, reduce costs, and enable regulated healthcare provider owned clinics to focus their resources on delivering timely and effective care, ultimately benefiting accident victims and enhancing overall access to rehabilitation services.

How does the HSP licensing framework compare with approaches in other jurisdictions, and is it aligned with best practices for maximizing consumer benefits?

Answer: Unfortunately, Ontario is unique in that it is the only jurisdiction, both within Canada and globally, that imposes an additional licensing framework specifically for regulated healthcare professionals treating auto insurance patients. In other provinces and jurisdictions, healthcare providers are regulated solely through their professional colleges, which are sufficient for ensuring high standards of care, compliance, fraud prevention, and ethical conduct.

This additional layer of regulation in Ontario contributes to higher administrative burdens and increased costs for healthcare providers—burdens not seen elsewhere. It also correlates with Ontario having some of the highest auto insurance rates in Canada. Removing HSP licensing in the current form will align Ontario with best practices from other regions, where healthcare professionals operate under a single regulatory body, could help streamline operations and reduce unnecessary costs.

By eliminating redundant layers of regulation, Ontario could create a more efficient system that enhances consumer access to care, reduces costs, and supports healthcare professionals in focusing their efforts on patient care rather than duplicative compliance. This approach would bring Ontario's practices in line with other successful regulatory models and ensure a leaner, more effective regulatory environment for both consumers and providers.

Has the FSRA and The FSCO been supportive of the healthcare professionals during licensing?

Answer: No, and the situation seems to be worsening with the current FSRA oversight of HSP licensing. FSRA seems to be a disconnected in wanting to engage and support healthcare professionals voicing issues of insurer malfeasance. Healthcare professionals, who are already bound by rigorous ethical standards raise broader issues based on their observations of the healthcare landscape, such as insurer abuses of process, concerns within both open and closed Preferred Provider Networks (PPNs) or reporting on healthcare topics highlighted in newspapers like the Globe and Mail. These concerns, rooted in an ethics-driven approach, do not align directly with FSRA's predominantly rules-based, compliance-focused framework. As a result, FSRA seems to not understand or want to act on these issues of insurance company inappropriateness as promptly as healthcare professionals expect.

FSRA seems to see healthcare professional needs and concerns as unimportant. For instance, during the 2023 FSRA Exchange, healthcare professionals were surprised when the CEO expressed a lack of awareness regarding FSRA's role in setting professional fees. This gap in understanding highlighted a disconnect between leadership and the realities faced by healthcare providers. Similarly, at the 2024 FSRA Exchange, healthcare professionals' questions about the HSP licensing framework remained unanswered, despite prior assurances that they would be addressed.

Healthcare professionals acknowledge that FSRA may be navigating unfamiliar territory, as their rules-based approach may not always align with the expectations of healthcare providers who are accustomed to addressing issues with immediacy and flexibility. By developing a more collaborative and open dialogue with healthcare professional, FSRA could bridge this gap, creating a more effective partnership that better serves both the healthcare community and consumers.

The most efficient and effective treatment frameworks are those created within a solid ethical foundation and carried out by providers with strong ethical values. So, if the FSRA were to lean into the values of ethical treatment it could better understand that rules and compliance-based regulation will fall short in preventing insurance company abuses of process and behaviours that although technically legal increase costs to the system and to the consumer.

Should HSP licensing continue in its current form, or if adjustments are needed, such as whether it should apply to all healthcare providers or only specific parties?

Answer: The current form of HSP licensing is not the most efficient for consumers, or healthcare providers, particularly those who are already regulated by their professional colleges. For regulated healthcare professionals who own and operate clinics, the additional licensing requirements create an unnecessary administrative burden and

duplicate the oversight already provided by their regulatory colleges. This not only adds costs but also diverts time and resources away from patient care.

A more effective approach could involve adjusting the framework to focus only on non-regulated entities, such as businesses not managed by regulated healthcare professionals. By narrowing the scope of HSP licensing, FSRA could concentrate its resources where oversight is genuinely needed, ensuring that businesses without existing regulation are adequately monitored.

This targeted adjustment would reduce duplication, align with best practices seen in other jurisdictions, and create a fairer and more efficient system that supports healthcare professionals while safeguarding consumers. Such a move would also demonstrate the Ministry's commitment to refining the system to better serve all stakeholders involved.

The auto insurance framework has a bad habit of trying to come up with solutions in a silo. This means it prefers to reinvent the wheel, resulting in inefficiencies.

As a healthcare professional my training has taught me to approach problems with humility and look outside of myself for help, relying on research and studies from other countries and other sectors; financial services is doing the opposite. It disbanded the Health Service Provider Advisory Committee and disregards healthcare professional input on the systemic inefficiencies. People in ivory towers have been trying to improve the Ontario Auto insurance framework for 25 years and it's only getting worse and more expensive while accidents keep decreasing.

By replicating healthcare college oversight within the Health Service Provider (HSP) licensing framework, by creating HCAI rather than using Telus, by using expensive dueling assessments from insurance company closed preferred provider networks instead of existing systems for second and third opinions, the auto insurance treatment framework adds unnecessary complexity.

This approach leads to the creation of **less efficient and more expensive processes** to achieve what could be done at significantly lower costs within the established regulatory structures.

The additional expenses incurred are ultimately borne by auto insurers and, consequently, passed on to consumers through higher premiums. Adopting a more streamlined, LEAN approach that leverages existing systems rather than duplicating them would improve efficiency, reduce costs, and benefit all stakeholders involved.

FSRA Proposed Initiatives:

Initiative A: Opportunity to Modernize HSP Licensing Through FSRA Process and System Improvements

Initiative A, with its significant investments in technology, appears to be using computers and AI to solve what is fundamentally a system design issue. LEAN principles, which emphasize efficiency and eliminating waste, suggest that the focus should not be on adding complexity but on streamlining the framework. The core problem isn't the lack of technology but rather the need for a more targeted and efficient approach.

The solution is simpler and more aligned with LEAN management: instead of reinventing the wheel within FSRA, the focus should shift to unregulated providers who genuinely need oversight. By directing resources toward these entities, FSRA can prevent gaps in regulation, ensuring that investments provide clear value for money. This approach would streamline the system, eliminate unnecessary duplication, and maximize the efficiency of FSRA's efforts, aligning with both LEAN principles and the needs of the sector.

Initiative B: Modernizing Supervisory Approach with a New HSP Supervisory Tool

While Initiative B aims to centralize data and enhance FSRA's supervisory capabilities through technology, it closely mirrors Initiative A by prioritizing technological solutions without addressing the underlying design flaws of the HSP framework. The proposal suggests using a centralized tool to manage data and improve compliance decision-making; however, it does not address the fundamental question of whether additional oversight is necessary for healthcare professionals who are already effectively monitored by their regulatory colleges.

The initiative's unspecified, long-term timeframe lacks the clarity and urgency needed to implement meaningful changes. Without a concrete and actionable plan, it risks being perceived as more of a placeholder than a solution. A more effective approach would be to shift focus toward unregulated entities that truly require oversight, streamlining the system in accordance with LEAN principles to maximize value for money and establish a sustainable, efficient operation.

By refining the HSP framework in this way, FSRA could align its resources more effectively with the actual needs of the sector. This would demonstrate a genuine commitment to developing a lean, efficient regulatory environment that delivers tangible benefits and better supports both healthcare professionals and consumers.

Initiative C: Opportunity to Enhance Cooperation and Collaboration with Regulatory Health Colleges (RHC)

It is profoundly incorrect to state that not all Regulated Health Colleges (RHCs) focus on the billing and financial aspects of their members.

The regulated health professionals act which oversees all healthcare colleges ensures regulated health colleges regulate health professionals to provide health services in a safe, professional and **ethical manner**. All colleges are mandated to ensure the ethical practices of their registrants in all aspects of their interactions with the healthcare system and the public. It is misleading to suggest that billing and financial aspects are not a focus for RHCs. **Fraud and unethical behaviour, including improper billing practices, are always a central concern of regulatory colleges**. Any college whose members have exposure to invoicing—whether through direct billing to the public or third parties like insurance companies—has strict guidelines that demand accuracy and ethical conduct in all invoicing practices.

To state that not all Regulated Health Colleges (RHCs) focus on the billing and financial aspects of their members is a misleading statement, as every college that oversees healthcare professionals involved in Motor Vehicle Accident (MVA) patient care enforces billing and invoicing standards. Such standards are fundamental to maintaining public trust and ensuring that healthcare providers operate with integrity.

If the FSRA believes that not all regulatory health colleges focus on the billing and financial aspects of their members, it needs to shut down licensing immediately since the truth has left the building. The reality is that every regulatory college is deeply intertwined with the financial and billing practices of its members, overseeing compliance, fee structures, and financial accountability. Stating this is a complete denial of the core regulatory responsibilities these colleges uphold, rendering FSRA's licensing approach not only redundant but misguided. Continuing with licensing under this false assumption only harms professionals, burdens patients, and creates an illusion of oversight without substance.

A critique of Initiative C reveals a fundamental redundancy in FSRA's approach. The initiative proposes enhancing cooperation between FSRA and RHCs but does not adequately explain how this partnership would add value beyond what RHCs are already achieving. Given that all RHCs are already focused on ethical billing practices, FSRA's involvement appears duplicative.

FSRA's Health Service Provider Market Conduct Report rely heavily on monitoring healthcare colleges' websites to obtain leads on potential bad behaviour. This practice highlights that, contrary to the claim that RHCs are not interested in billing oversight, they are, in fact**, leading the way.** If FSRA is looking to RHCs for information, it suggests that the colleges are ahead of market conduct efforts, and FSRA's additional oversight may be redundant.

Per the 2022-2024 market conduct report: "FSRA monitors health regulatory college websites to identify sanctions placed against Regulated Healthcare Professionals (RHPs)." This seems like "busy work" that you do when there isn't much going on.

Moreover, the initiative's suggestion that FSRA must negotiate 27 individual information-sharing agreements with each regulated health college raises concerns about efficiency and practicality. If RHCs are already effectively managing billing and compliance, FSRA's role should be distinct, focusing on areas where regulation is genuinely needed, such as unregulated entities. The lack of clarity in this proposal's objectives and the absence of evidence to support claims about RHCs' lack of interest in financial oversight suggest a need for FSRA to re-evaluate its approach. A more effective strategy would be to concentrate on areas where FSRA's involvement could fill regulatory gaps rather than duplicate the efforts already effectively managed by healthcare colleges.

Initiative C appears to misunderstand the core responsibilities of healthcare colleges and risks adding more unnecessary layers of regulation. FSRA should focus on areas where its oversight can provide distinct value, ensuring that resources are used efficiently and in alignment with the public interest.

FSRA Initiated HSP Framework Review Consultation questions:

1. What features should an HSP licensing system focus on to have better user functionality?

To enhance user functionality, an HSP licensing system should focus on the following features:

1. **Eliminate Duplicate Licensing**: The system should remove redundant licensing requirements for healthcare professionals who are already regulated by their Regulatory Health Colleges (RHCs). This would streamline processes, minimize administrative burdens, and prevent duplicate oversight, ensuring that healthcare providers can focus on patient care rather than managing multiple layers of compliance.
2. **Targeted Oversight for Unregulated Entities**: The system should focus its resources on unregulated entities that genuinely need oversight, such as tow truck operators or body shops, rather than healthcare professionals who are already under college regulation. This approach would ensure that the system serves its purpose efficiently by addressing gaps in regulation while eliminating unnecessary burdens on regulated providers.
3. **User-Friendly Interface and Support**: From a user perspective, the system should be intuitive, easy to navigate, and provide clear guidance. Features like live chat support or a help desk should be available to assist healthcare providers quickly and efficiently, reducing frustration and improving overall user satisfaction.

2. Are there any concerns/considerations FSRA should keep in mind when developing and implementing the HSP Supervisory Tool?

When developing and implementing the HSP Supervisory Tool, FSRA should consider the following concerns to ensure the tool is effective, efficient, and aligns with the needs of healthcare professionals and consumers:

1. Avoiding Redundancy: FSRA should be mindful of the existing oversight provided by Regulatory Health Colleges (RHCs). The tool should not duplicate efforts already carried out by RHCs, such as compliance monitoring, billing oversight, and ethical practices. Instead, FSRA should focus on enhancing areas where RHCs may not currently have oversight, such as unregulated entities or businesses, to ensure the tool adds value without creating unnecessary burdens for healthcare professionals.

2. User-Centric Design: The supervisory tool should prioritize user experience, ensuring it is intuitive and easy for healthcare professionals to navigate. FSRA should provide clear, practical guidance and support for users, including live assistance, to minimize confusion and improve compliance rates.

3. Clear Focus on Unregulated Entities: FSRA should consider using the tool to focus specifically on unregulated entities or areas where gaps in oversight exist, such as tow truck operators and body shops. This targeted approach would maximize the tool's impact and ensure that FSRA's efforts are directed where they are most needed, rather than imposing additional compliance requirements on regulated healthcare professionals who are already monitored effectively by their colleges.

What areas of licensing and supervision can RHCs and FSRA work together on to better alleviate issues in the sector?

FSRA and Regulatory Health Colleges (RHCs) should collaborate in the following ways to better address issues in the sector while respecting the expertise and oversight RHCs already provide:

1. Respecting and Leveraging RHC Expertise: FSRA should recognize the generational knowledge and expertise that RHCs bring to regulating healthcare professionals. Rather than attempting to duplicate these efforts, FSRA should defer to the comprehensive oversight already established by RHCs, which have a proven track record of ensuring compliance and ethical behaviour. The FSRA data clearly shows that invoice fraud among regulated healthcare professionals is virtually nonexistent; thus, FSRA's efforts should focus elsewhere.

2. Concentrating on Unregulated Entities: FSRA's resources would be more effectively deployed by targeting unregulated entities such as tow truck operators and body shops, where there are genuine gaps in oversight. By focusing on areas where regulation is genuinely needed, FSRA can avoid adding unnecessary administrative layers for healthcare professionals who are already under the rigorous supervision of their respective colleges.

3. Revising Compliance and Audit Processes: By acknowledging that RHCs already effectively manage compliance for healthcare professionals, FSRA can stop unnecessary audits and administrative requirements for these professionals. Instead, FSRA should develop a compliance model that only applies to entities not regulated by healthcare colleges, thereby reducing administrative burdens and respecting the regulatory expertise that RHCs provide.

4. Targeted Training and Support for Non-Regulated Sectors: FSRA could learn from RHCs to offer targeted training and support for non-regulated sectors that lack the structure and guidance healthcare professionals receive. By focusing on where there is a real need for oversight and improvement, FSRA could ensure its resources are better allocated to serve public interest without interfering with the work already done by RHCs.

5. FSRA should learn from the ethical framework within the healthcare colleges and adopt these lessons to insurance company behaviours that are reported by healthcare professionals.

   FSRA should focus on unregulated entities and trust the proven oversight of RHCs. By shifting resources and efforts away from regulated professionals who already demonstrate high compliance, FSRA can create a more efficient, streamlined system that reduces administrative burdens and maximizes value for consumers.

How can FSRA help to ensure that prioritized initiatives / changes are communicated to HSPs and other stakeholders?

1. Using Clear Communication Channels: Establish a dedicated portal, regular emails, and newsletters to keep HSPs informed with timely updates. Reinstitute the HSP advisory committee with a broader mandate to address all areas of concern for Health Service Providers.

2. Hosting Webinars and Town Halls: Regular online sessions will help explain changes, answer questions, and gather feedback from stakeholders directly.

3. Partnering with Professional Associations: Collaborating with associations and RHCs can help spread information quickly through established, trusted networks.

4. Providing Simple Educational Resources: Create easy-to-understand guides, FAQs, and videos to explain new policies clearly.

5. Collecting Feedback: Set up simple anonymous feedback forms or surveys to ensure FSRA understands stakeholder concerns and can adjust communication as needed.

This approach keeps information clear, accessible, and responsive.

HSP Section Conclusion

The long-term goal of creating a sustainable, efficient system that benefits consumers, insurers, and healthcare professionals alike is one that requires thoughtful consideration. This consultation on the HSP licensing framework offers a valuable opportunity for positive change and improvement. Let's make the most of this chance to create a more effective and streamlined system for everyone involved.

While oversight is essential to maintain integrity in the healthcare sector, it's critical to have the right amount of oversight tailored to the specific needs of the system and those it regulates. Regulatory circles call this type of LEAN regulation "right touch" regulations. Ontario's healthcare professionals are already subject to rigorous, ethical, and effective oversight through their respective healthcare colleges, which are designed to uphold high standards across all aspects of professional practice, including billing and fraud prevention.

By duplicating these efforts, the HSP licensing framework has added detrimental administrative and financial burdens without delivering demonstrable benefits. Data shows that fraud among regulated healthcare providers is virtually nonexistent, suggesting that the additional layer of oversight may not be needed. A more efficient approach would be to trust in the existing healthcare regulatory framework, which has proven successful over generations, and focus on optimizing resources where they are genuinely needed.

Removing the HSP licensing framework would streamline regulatory processes, allowing healthcare professionals to focus on delivering quality care without the burden of redundant compliance. This would enhance patient access, reduce costs, and align Ontario's practices with other successful jurisdictions. By reallocating FSRA's resources toward areas where oversight is truly required—such as unregulated sectors like tow truck operators and body shops—FSRA could make a more meaningful impact and address long-standing gaps in the auto insurance sector.

Ultimately, the goal is to create a balanced and sustainable system that delivers value for money, enhances efficiency, and supports healthcare professionals, consumers, and insurers alike. A system that is well-designed, focused, and responsive to stakeholder concerns will yield better outcomes, reduced inefficiencies, and a stronger foundation for Ontario's healthcare and insurance landscape.

HSP Section Recommendations:

Remove HSP Licensing

- Eliminate the redundant licensing system for regulated healthcare professionals.

Focus on High-Risk Areas

- Redirect FSRA resources to unregulated sectors like tow truck operators and body shops. HSP licensing could focus on health service providers **not** controlled by a regulated healthcare professional.
- Address issues highlighted by the Auditor General's report, focusing on vehicle-related services lacking oversight.

Stakeholder Engagement

- Involve healthcare providers in regulatory reform discussions to ensure changes address their concerns.
- Reinstate the HSP Advisory Committee, ensuring it reports directly to the Board (not FSRA executives) and is composed of healthcare professionals unaffiliated with insurance company PPNs.
- This committee would provide a formal platform for physiotherapists, chiropractors, and other healthcare providers to address systemic misinterpretations and advocate for fair practices.

Provide Standardized Reference Materials for Insurance Adjusters

Healthcare professionals have long requested clear, standardized guidelines for adjusters to reduce misinterpretations of treatment programs. Providing reference materials, such as FAQs and structured guides, would ensure adjusters adhere to consistent practices, reducing unnecessary disputes and improving fairness.

Increase FSRA Oversight on Insurer Practices

FSRA's current lack of involvement in addressing "minor" disputes allows insurers to engage in bad-faith practices unchecked. Enhanced oversight would hold insurers accountable for their misinterpretations of treatment programs and protect healthcare providers and patients from unfair practices.

Reestablish a True HSP Advisory Committee

- Ensure the committee reports to the board and not FSRA executives for unbiased input and can comment all aspects of healthcare related insurer behaviour to ensure consumer safety and protection.

Trust in Existing Healthcare Regulators

- Leverage the thorough and effective oversight of healthcare regulatory colleges to avoid duplicating efforts.

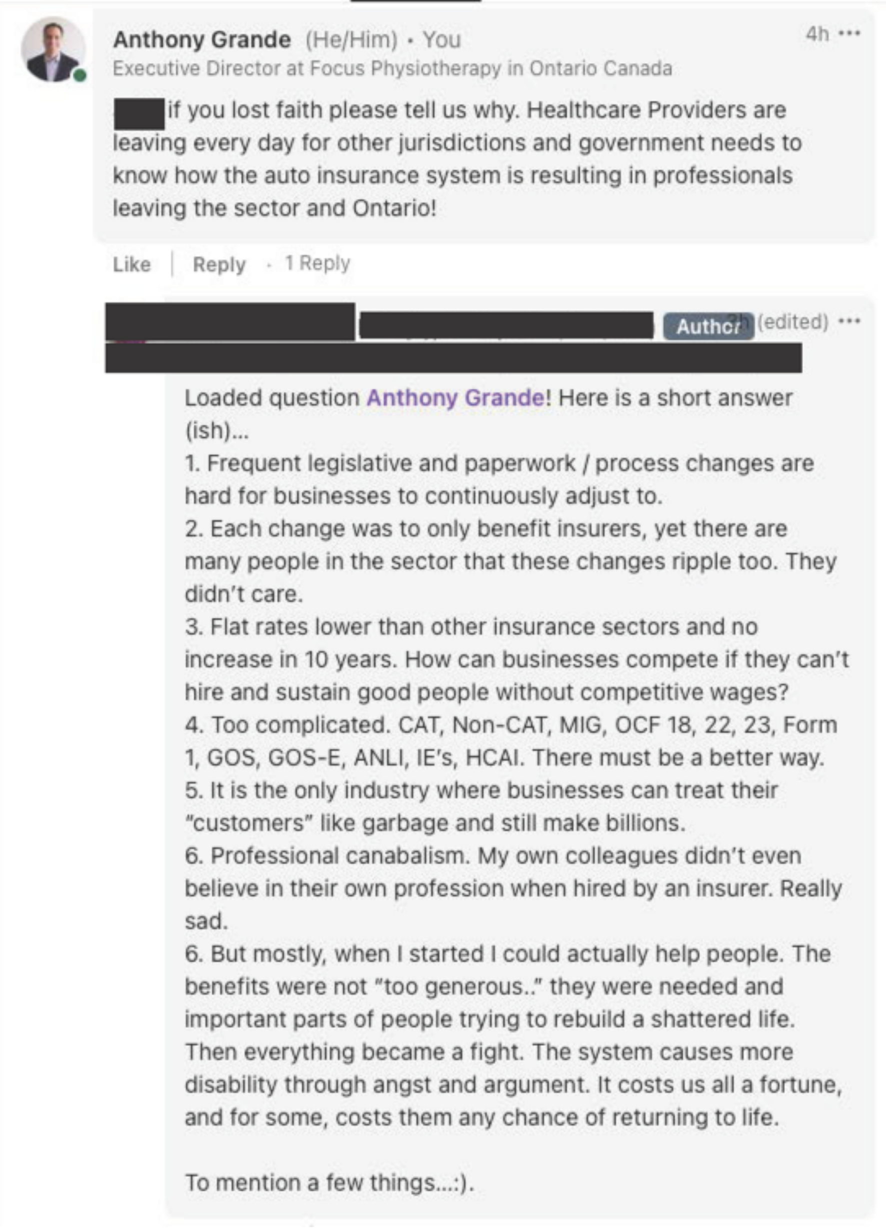
Focus on Areas Needing Attention

- Allocate FSRA resources to unregulated entities like tow truck operators and body shops for better use of government funds and reduced auto insurance costs.

Improving Patient Access

- Remove redundant regulations to encourage healthcare providers who left due to licensing complexities to return, enhancing patient access to care.

Item of interest: this is what Former Presidents of Healthcare Colleges are saying regarding the effect of FSRA licensing when asked:


Anthony Grande (He/Him) • You
Executive Director at Focus Physiotherapy in Ontario Canada
4h

if you lost faith please tell us why. Healthcare Providers are leaving every day for other jurisdictions and government needs to know how the auto insurance system is resulting in professionals leaving the sector and Ontario!

Like | Reply · 1 Reply

Author (edited)

Loaded question Anthony Grande! Here is a short answer (ish)...
1. Frequent legislative and paperwork / process changes are hard for businesses to continuously adjust to.
2. Each change was to only benefit insurers, yet there are many people in the sector that these changes ripple too. They didn't care.
3. Flat rates lower than other insurance sectors and no increase in 10 years. How can businesses compete if they can't hire and sustain good people without competitive wages?
4. Too complicated. CAT, Non-CAT, MIG, OCF 18, 22, 23, Form 1, GOS, GOS-E, ANLI, IE's, HCAI. There must be a better way.
5. It is the only industry where businesses can treat their "customers" like garbage and still make billions.
6. Professional canabalism. My own colleagues didn't even believe in their own profession when hired by an insurer. Really sad.
6. But mostly, when I started I could actually help people. The benefits were not "too generous.." they were needed and important parts of people trying to rebuild a shattered life. Then everything became a fight. The system causes more disability through angst and argument. It costs us all a fortune, and for some, costs them any chance of returning to life.

To mention a few things...:).

Quote from the Former CEO of the Ontario Physiotherapy Association:

As a regulated health profession, regulation is through the RHPA and the College of Physiotherapists of Ontario. Additional regulation, such as FSRA Licencing, is redundant in many aspects and regulated health professions should not be treated the same in that system.

Dorianne Sauve

Former CEO of the Ontario Physiotherapy Association

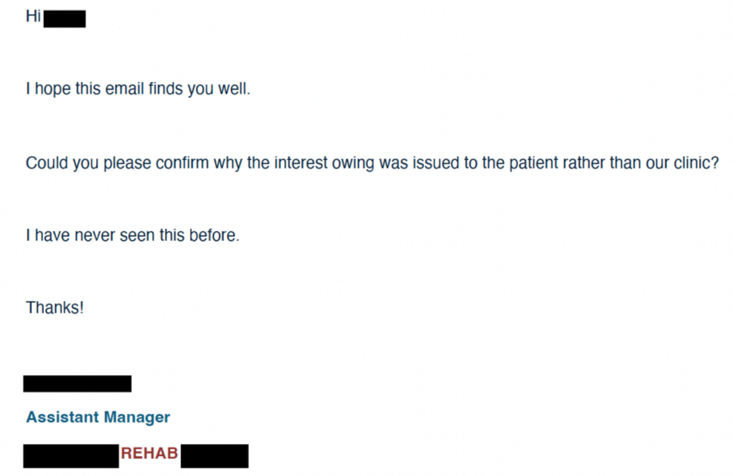
Audit Findings, Tribunal Decisions, and Ongoing Mismanagement of Direct Payments:

15 Years of Insurance Adjuster MIG Confusion and Issues with HSP Licensing

These are not isolated incidents but rather common, daily challenges that healthcare professionals face. Despite the purported "benefits of HSP licensing" the reality tells a different story. It's a 'death by a thousand cuts,' where the constant disrespect and frustration stem from an industry that seems intent on confrontation and being unnecessarily difficult.

The aggressive approach to claims management only serves to further erode the professional integrity of those who are simply trying to provide care.

Example 1: Direct Payment Issue



Hi

I hope this email finds you well.

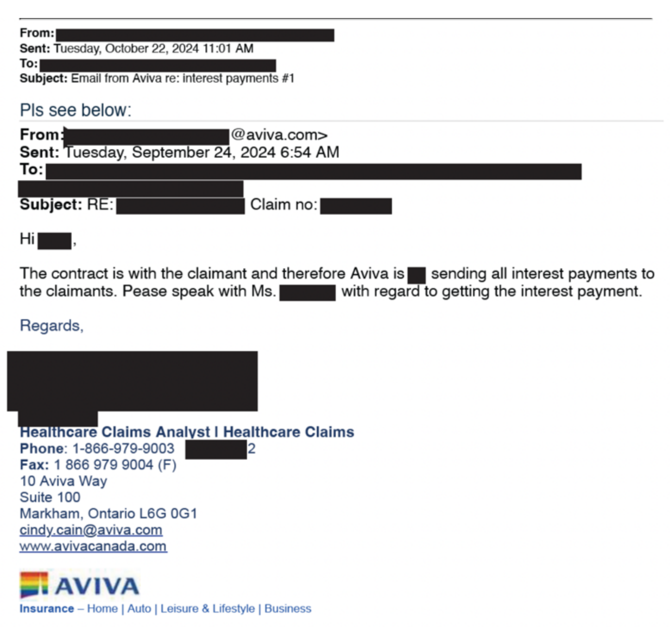
Could you please confirm why the interest owing was issued to the patient rather than our clinic?

I have never seen this before.

Thanks!

Assistant Manager

REHAB



From:
Sent: Tuesday, October 22, 2024 11:01 AM
To:
Subject: Email from Aviva re: interest payments #1

Pls see below:

From: @aviva.com>
Sent: Tuesday, September 24, 2024 6:54 AM
To:
Subject: RE: Claim no:

Hi ,

The contract is with the claimant and therefore Aviva is sending all interest payments to the claimants. Pease speak with Ms. with regard to getting the interest payment.

Regards,

Healthcare Claims Analyst I Healthcare Claims
Phone: 1-866-979-9003 2
Fax: 1 866 979 9004 (F)
10 Aviva Way
Suite 100
Markham, Ontario L6G 0G1
cindy.cain@aviva.com
www.avivacanada.com

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Healthcare professionals are increasingly frustrated with the endless bureaucratic hurdles that add layers of red tape and contribute to moral injury. In situations like this, we're forced to play games that undermine our profession, such as chasing patients for payments as small as five dollars. These inefficiencies are not only demeaning but also divert our focus from patient care, where it truly belongs. HSP licensing has done nothing for us.

Example 2: Direct Payment Issue and Interest Calculation Issue

Email 1 from a Clinic

Good morning,

Our invoice wit[redacted] has been approved in the amount of $651.24 but we have not received the payment. Please release the payment with any accumulated interest.

Regards,

Email Reply from the Adjuster:

Good morning,

Please note, interest will be released to the claimant directly to provide to your clinic.

8

We have issued a cheque for $1.90 to claimant to reimburse you during their next appointment.

Warm regards,

Another Email to the Adjuster and a reply.

How did you calculate that amount? The invoice is 3 months overdue (Jan 9 – April 9). The interest is calculated at 1% per month, compounded monthly. The first month alone would be $651.24 x 0.1 = $6.51.

I have calculated the following:

7

0	–	–	$651.24
1	$6.51	$6.51	$657.75
2	$6.58	$13.09	$664.33
3	$6.64	$19.73	$670.97

Kindly provide the breakdown of you calculation.

Regards,

The conclusion is the clinic must calculate interest **for the insurance adjuste**r, then chase the patient for the payment.

Hello,

This was calculated using an online interest calculator tool.

Please provide the amount of interest owed and it will be issued to the patient to provide to you at their next appointment.

Warm regards,

Every delay and hurdle healthcare professionals face due to this type of nonsense, complicates the process for our patients and encourages people to exit the system. ***The confrontational approach to benefits management needs to stop.***

Example 3: Insurance Adjuster Not Understanding the MIG (yet it has been around for 15 years)

Dear ,

I have read your email, and this is not the first time I have had to correct adjusters regarding their understanding of the Minor Injury Guidelines.

Firstly, regarding block billing fees, there is absolutely no good faith being displayed on your part to pay MIG blocks in total, and we are not asking for good faith. The rules are explicit and state those block fees are payable at the end of the periods.

I will refer you to an email I received from the Financial Services Regulatory Authority of Ontario (BLUE SECTION) on this topic that confirms we are correct. You can call the regulator yourself.

> Based on what you have outlined below, it appears that as a Service Provider you scheduled treatment for the patient as agreed in the OCF 23 treatment plan and as such is entitled to the full block payment.
>
> This preliminary assessment is predicated on two factors:
>
> 1. The MIG treatment plan and associated payment (Block) is based on period of time, not number of visits, and the patient completed the twelve weeks of treatment (albeit, missing some scheduled sessions).
> 2. The MIG address pro-rated payments where the patient takes steps to discontinue the service/switch provider, as per Superintendent's **Guideline** No. 01/14 Financial Services Commission of Ontario, section 6 (link attached) http://www.fsco.gov.on.ca/en/auto/autobulletins/2014/Documents/a-01-14-1.pdf. There is no indication that the patient discontinued the treatment.
>
> If you are unable to reach a satisfactory resolution with the insurer, please follow the complaints process on our website (link attached)https://www.fsrao.ca/consumers/auto-insurance/how-resolve-auto-insurance-complaint. This starts by filing a formal complaint with the insurer and then escalating to us (FSRA), if unresolved. Our involvement in the process allows us to collect relevant information including supporting documents from all involved parties, in order to make an assessment.
>
> Best Regards,

With regards to monies owing for supplementary goods and services:

The patient presented at for evaluation and treatment. Upon assessment, our registered physiotherapist determined multiple injuries could be treated within the MIG guidelines with the addition of supplementary goods and services to address multiple body parts barring any unforeseen interruptions and despite barriers to recovery being present and documented.

An OCF-23 was completed and submitted to with documentation of the multiple injury sites as a barrier to recovery in the comments. The supplementary goods and services were identified as required in part 9 of the OCF 23 submitted to Aviva and were approved.

Our team provided treatment to additional areas of injury during MIG period consistent with the OCF-23 submitted and approved.

The information presented and conveyed to within the OCF-23, conformed to the standard submission

requirements.

Following submission of an OCF-21, our office received a call requesting clarification of the goods and services. Which was done.

Your assertion that supplementary goods and services are not payable is incorrect and this is not the first time I have had this conversation with an adjuster and in the end the supplementary goods and services are always payable as per the MIG guidelines since the following.

> *The MIG guidelines state:*
>
> *"d) For Supplementary goods and services during the treatment phase*
> *Additional funds are available to provide supplementary goods and additional services to support restoration of functioning and address barriers to recovery. The supplementary goods and services may include but are not limited to:*
>
> *□ Treatment services for the additional minor injuries arising from the same accident."*
>
> When considering what services or good to apply, the MIG guidelines also state:
>
> *"The health practitioner, a regulated health professional or an appropriate health care provider may provide the supplementary goods and/or services that are deemed necessary, up to a maximum cost of $400.00, without approval of the insurer."*

We have provided information for [redacted] to process payment for the supplementary goods and services provided to the patients.

I can refer you to the previous [redacted] supervisors or the Ombudsman to discuss this with or can simply speak to your supervisor.

I would hope that given I am reaching out to you directly you can take the time to confirm what I am saying and make payment in full.

[redacted]

Thanks,

[redacted]

Supervisor Response:

From: [redacted]
Subject: [redacted]
Date: [redacted]
To: [redacted]
Cc: [redacted]

Hi [redacted],
Thank you for your email.
We have decided to go ahead and pay the invoice as noted.

Have a good day.
Thanks,

[redacted]
Healthcare Manager [redacted]

Example 4: Exploitative Miscommunication in Early Insurance Claims, Direct Payment Myths

The following letter from an insurer reflects the core issue of how insurance adjusters might exploit vulnerabilities through misleading communication, particularly targeting lower-income, non-native English speakers, and the consequential ethical and financial implications.

In the context of the legal questionable practices observed in the early stages of insurance claims, a concerning scenario emerges where insurance adjusters may exploit the vulnerabilities of lower income, non-native English speakers. The adjuster, deviating from standard practices, verbally communicates in a way that suggests to the patient that the funds provided by the insurance are for general use, rather than explicitly for medical treatments. This tactic seems intentionally designed to create a misunderstanding and the written letter never seems to correlate with the patient's recollection of what was stated.

The strategy appears to be as follows: The adjuster, aware of the patient's limited proficiency in English and financial insecurity and lack of legal representation, provides information that is technically accurate but misleading. The patient, believing the funds are for discretionary use, might spend them on immediate, non-medical needs. This spending is exactly what the adjuster anticipates.

The real problem surfaces when the clinic, expecting payment from the insurance, discovers that the funds were sent directly to the patient and have already been spent. The patient, now trapped in a financial and medical dilemma, is unable to pay for the necessary treatments. At this point the patient may discontinue treatment for months not wanting to face the clinic it owes money too.

The patient is left in a precarious situation, burdened with unpaid medical bills and the need for ongoing healthcare, which they can no longer afford. This situation highlights a deliberate and what legally unethical manipulation by the adjuster, who deviates from standard ethical practices in the hopes of the patient misusing the funds. It's a tactic that not only takes advantage of the patient's language barrier but also places them in a financially and medically vulnerable position. This approach by the insurance adjuster is a clear deviation from ethical conduct and underscores the need for stricter regulatory oversight and stronger protections for non-native English speakers in the insurance process.

This process can feel like a **consumer trap**, effectively "killing" the claim by creating a financial pitfall for the patient. The result? The patient is left worse off, burdened with debt and lacking access to the rehabilitation support they needed in the first place. The clinic was not informed of this arrangement, until is submitted an invoice for MIG care.

August 25, 2023

Dear

As we discussed earlier today on August 25, 2023, the injuries you described appear to be soft tissue and categorized as a minor injury under your policy. A "Minor Injury" is defined as

> *"One or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury."*

As an insured person with a minor injury, you are entitled to treatment under the Minor Injury Guideline (MIG). This guideline establishes a treatment framework in respect of minor injuries. If you would like to review this guideline, go to http://www.fsco.gov.on.ca/en/auto/autobulletins/2011/documents/a-06-11-1.pdf

I would like to give you the opportunity to access the treatment you need under the MIG without the need to submit forms to . Section 41 of the Statutory Accident Benefits Schedule permits an insurer to dispense with the need for the "OCF-23" treatment form if we give you, the insured person, notice that we are offering to "pay for the goods and services described in the Minor Injury Guideline without the submission of a treatment confirmation form."

Treatment under the MIG is intended to cover a 12 week period of rehabilitation. As you have accepted this offer of simplified treatment, I will send you $2,200 for treatments for the treatments that you require. You may select a treatment provider of your choice or we can recommend a provider to you. It is your responsibility to pay the provider directly for treatment.

This is not an offer to settle your claim for accident benefits. This is simply an easier way for you to access treatment under the MIG.

If you require more treatment. Your healthcare provider may be required to submit records of your treatment history for review. Please hold on to all receipts, as they will need to be reviewed for further treatment.

Should you have any questions or require assistance please do not hesitate to contact the writer at the number below.

Sincerely,

Private & Confidential / Privé et Confidentiel

2 of **2**

These examples exemplify how the adage, 100% of problems are known by front line employees, it’s time for FSRA and Government to listen to us if they want to create a sustainable system.

Health Service Provider Licensing: Actual Audit Findings

The stated goal of Health Service Provider licensing is to ensure invoice accuracy and prevent invoice fraud, but in practice, it seems that the Financial Services Regulatory Authority (FSRA) is more focused on strict paperwork compliance since invoice fraud is virtually nonexistent amongst regulated healthcare professionals.

The reality is that healthcare professionals, particularly those treating motor vehicle patients with chronic pain, are already working under challenging circumstances, and this heavy compliance focus only adds to the strain without addressing the actual issues.

For example, the following audits have demonstrated that so-called "noncompliance" often stems from minor or irrelevant issues or in many cases misunderstanding poorly worded questions.

One audit found a clinic noncompliant because a 12-year-old didn't have ID—but children of that age don't carry driver's licenses. (attached)

In another case, an auditor incorrectly claimed that a clinic required yearly signoffs on policies and procedures manuals. (attached)

Finally, the case of 1631776 Ontario Inc. o/a South Barrie Health Group v. Ontario (Superintendent Financial Services), a new receptionist in a clinic mistakenly billed a service on the wrong date, which was deemed invoice fraud by the auditor, leading to a lengthy years long process with the Financial Services Tribunal, before the healthcare professional was ultimately vindicated.

(attached as a link
https://www.canlii.org/en/on/onfst/doc/2018/2018onfst7/2018onfst7.html?resultId=336572730ea64a40a086471a100411ba&searchId=2024-10-05T23:18:17:144/31bc3df1587a4ed6a2ba2a95f640fe84&searchUrlHash=AAAAAQAZc291dGggYmFycmllIGhlYWx0aCBncm91cAAAAAA

These following are examples of how the licensing system is focused on compliance for the sake of compliance, rather than preventing fraud. When healthcare professionals see their trivial issues make up the yearly list of enforcement actions the FSRA publishes it's very discouraging since they are already working in a highly regulated sector. Regardless of the FSRA stating within this consultation document they have reduced the administrative burden by 30%, this is not the lived experience of a healthcare professional who is already regulated by a healthcare college and is trying to keep up with the FSRA demand of, "one more thing".

Due to the honesty of these healthcare professionals and steadfast presence of regulatory health colleges, regulated healthcare professionals are deeply committed to avoiding invoice errors. This dedication is ingrained in us through our professional standards, ensuring that every regulated clinician, as well as every clinic owner who is a clinician, would think thrice before jeopardizing their career through invoice fraud. The potential consequences are simply too significant. And for those bad apples that would commit invoice fraud, the presence of a second licensing agency is not a deterrent.

HSP Audit Exit Notes 1

EXIT MEETING NOTES

The following was discussed with the Principal Representative on:

Examination Program Sections	Issues Noted	Remedial Plan	Reference
Licensure Validation Section	None noted	N/A	N/A
Business Facility and Operations	There currently is no master business licence for Company X	If the company is to operate with any other name besides it's full legal name, a master business licence is required.	Provincial [1] requirement
Know Your Service Provider	None noted	N/A	N/A
Section 1: Provision of Information	None noted	N/A	N/A
Section 2: Billing Practices	None noted	N/A	N/A
Section 3: Business Systems & Practices	Policies and procedures exits, but there no formal date stamp/annual sign off.	Its recommended to have an annual sign off/date stamp on policy and procedures.	O. Reg 90/14, s. 17 [2]
Section 4: Reporting Information to FSCO	None noted	N/A	N/A
Section 5: Principal Representative -Eligibility -Powers and Duties	None noted	N/A	N/A
Section 6: File Walkthrough	None noted	N/A	N/A

FOLLOW UP EXAMINATION DATE: N/A

[3]

Please be informed that the items noted with a '*' are considered to be 'best business practice' items which FSCO recommends that the Service Provider implement and include within its Policies and Procedures, and/or implement as a part of its business practice. The Exit Meeting Notes are subject to review; changes, if any, will be reflected in the Closing Letter.

Signature of Principal Representative:

Signature of Senior Compliance Officer:

In this case, the provider's full legal name was confirmed by the auditor, making a master business license unnecessary, yet a remedial plan was still issued. The clinic owner had to spend an entire day on a compliance issue that had no impact.

Additionally, employees were asked to sign off on policies annually, supposedly to prevent fraud, though FSRA confirmed it wasn't a regulatory requirement. This unnecessary step further distracted from patient care.

Despite no fraud or invoicing issues, clinics received warning letters and remedial plans for trivial matters, making the audit process seem more about bureaucracy than improving care. Healthcare professionals are frustrated by regulations that add red tape without enhancing patient outcomes.

HSP Audit Exit Notes 2:

Examination Program Sections	Issues Noted	Remedial Plan	Overall Risk	Reference
Licensure Validation Section	Year end of the corporation noted in the application September 30 when it is actually June 30	Go to FSCO website and amend application. Otherwise contact FSCO Licensing for assitance	[1] Low	
Business Facility and Operations	No items noted	N/A	N/A	
Section 1: Provision of Information	No items noted	N/A	N/A	
Section 2: Billing Practices	There is no identification of the patient before treatment	Going forward the PR will establish a method for verification [2]	Medium	O.Reg 90/14 S17
Section 3: Business Systems & Practices	no items noted	N/A	N/A	
Section 4: Reporting Information to FSCO	No items noted	N/A	N/A	
Section 5: Principal Representative -Eligibility -Powers and Duties	No items noted	N/A	N/A	
Section 6: File Walkthrough	no items noted	N/A		

Please be informed that the items noted with a "*" are considered to be 'best business practice' items which FSCO recommends that the Service Provider implement and include within its Policies and Procedures, and/or implement as a part of its business practice. The Exit Meeting Notes are subject to review; changes, if any, will be reflected in the Closing Letter.

The corporation's fiscal year-end change, though properly reported in the next Annual Information Return (AIR), was flagged by the auditor as a risk. Despite no mid-year reporting obligation, the auditor issued a remedial plan, which the clinic owner saw as unnecessary overreach, distracting from patient care.

Another issue involved ID for a minor patient. While other files had identification, the minor only had a health card without a photo due to their age. The auditor still stated this was not enough proper verification. With no evidence of fraud, the clinic owner felt the remedial plan was unfair and excessive.

These examples highlight the frustration healthcare professionals face when audits focus on administrative details unrelated to patient care, diverting attention from delivering quality service.

Disproportionate Penalties for Minor Clerical Errors: The Case of South Barrie Health Group v. Ontario (Superintendent of Financial Services)

This case exemplifies what current behaviours continue to be. Despite this being years ago and with the FSCO, the same auditors and behaviours exist at FSRA today.

In the following case of South Barrie Health Group v. Ontario (Superintendent of Financial Services), it seems highly unfair that the Financial Services Commission of Ontario (FSCO) took this matter so far. The healthcare provider, South Barrie, was penalized for what can be described as minor clerical errors, such as discrepancies between clinic calendars and invoices. The Tribunal acknowledged that services were, in fact, provided, despite FSCO's insistence on administrative penalties. These errors, while technically incorrect, do not amount to fraud but rather reflect overly rigid adherence to rules that don't account for the realities of healthcare operations, where scheduling can change on short notice.

The healthcare provider's efforts to comply with the rules and rectify any mistakes were overlooked in FSCO's attempt to impose penalties. While FSCO's role is to maintain regulatory standards, applying this level of strictness for minor discrepancies seems disproportionate and not in line with how a healthcare regulator would typically approach such issues. The Tribunal's ruling underscores that South Barrie acted in good faith, providing the services billed for, even if some administrative details didn't align perfectly with documentation. This situation demonstrates how adhering too closely to the letter of the law, without flexibility for reasonable errors, is just unreasonable.

FINANCIAL SERVICES TRIBUNAL

Citation: 1631776 Ontario Inc. o/a South Barrie Health Group v. Ontario (Superintendent Financial Services),
2018 ONFST 7
Decision No. SP738-2017-1
Date: 2018/04/25

2018 ONFST 7 (CanLII)

IN THE MATTER OF the *Insurance Act*, R.S.O. 1990, c. I.8, as amended (the "Act"), in particular sections 441.1, 441.2 and 441.3;

AND IN THE MATTER OF a Notice of Proposal to Impose an Administrative Monetary Penalty dated June 2, 2017 issued by the Executive Director, Licensing and Market Conduct Division by delegated authority from the Superintendent of Financial Services;

AND IN THE MATTER OF a Hearing in accordance with subsection 441.3(5) of the *Insurance Act*, R.S.O. 1990, c. I.8.

B E T W E E N:

1631776 ONTARIO INC. o/a SOUTH BARRIE HEALTH GROUP

APPLICANT

and

SUPERINTENDENT OF FINANCIAL SERVICES

RESPONDENT

BEFORE:

Bethune Whiston
Chair of the Panel and Vice-Chair of the Tribunal

Jill Wagman
Member of the Panel and Member of the Tribunal

Christopher Portner
Member of the Panel and Member of the Tribunal

APPEARANCES:

For the Applicant – Dr. Alexander Ryzhykh, Principal Representative

For the Superintendent of Financial Services – Mr. Michael Spagnolo, Counsel

DATE HEARD:
January 31, 2018

REASONS FOR DECISION

I. INTRODUCTION

[1] On June 2, 2017, the Superintendent of Financial Services (the "Superintendent") issued a Notice of Proposal to Impose an Administrative Penalty ("NOP") of $4,000 on the Applicant, 1631776 Ontario Inc., operating as South Barrie Health Group ("South Barrie"). The Superintendent alleges that South Barrie, on two occasions, charged an amount in consideration for the provision of goods or services to or for the benefit of a person who claims statutory accident benefits or who otherwise claims payment under a contract of insurance, but did not provide the goods or services. The Superintendent alleges, in this regard, that South Barrie contravened paragraph 1 of subsection 3(2) of Ontario Regulation 7/00 and thereby engaged in unfair or deceptive acts or practices contrary to section 439 of the Act.

[2] At the hearing, South Barrie was represented by its Principal Representative, Dr. Alexander Ryzhykh ("Dr. Ryzhykh"). South Barrie did not challenge the fact that, in the case of two invoices submitted to insurance carriers, errors were made in one case in recording who performed certain services and, in the other case, there were inconsistencies between the clinic calendar and the invoice. Dr. Ryzhykh did, however, challenge the Superintendent's allegations that amounts were charged for services that were not performed.

[3] Having heard the evidence of both parties and considered all the evidence and submissions before us, we are not satisfied that the services were not performed. We direct the Superintendent not to carry out the NOP to impose an administrative penalty on South Barrie. The reasons for our decision follow.

II. THE ISSUES

[4] The issues have been framed as follows:

a) Did the Applicant charge an amount in consideration for the provision of goods or services to or for the benefit of a person who claims statutory accident benefits or who otherwise claims payment under a contract of insurance, where the goods or services were not provided, in contravention of paragraph 1 of subsection 3(2) of Ontario Regulation 7/00 and therefore engage in unfair or deceptive acts or practices contrary to section 439 of the Act?

b) If the answer to issue (a) is yes, is the imposition of the proposed administrative monetary penalty appropriate under section 441.3 of the Act and will it serve the purposes of subsection 441.2(1) of the Act?

c) If the answer to issue (b) is yes, what is the appropriate quantum of penalty taking into consideration the five criteria prescribed by section 4 of Ontario Regulation 408/12?

[5] As the Tribunal is not satisfied that the services were not performed, we have found the answer to issue a) is no. Therefore, we do not need to deal in these Reasons with issues b) and c).

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III. THE FACTS

[6] The following facts are taken, in modified form, from a very brief Agreed Statement of Facts:

a) 1631776 Ontario Inc., operating as South Barrie, is a licensed Health Service Provider under the Act, licence number SP13742.

b) Dr. Ryzhykh is designated as the Principal Representative of South Barrie.

c) Mr. P was an employee of South Barrie from February 5, 2015 to December 18, 2015.

[7] We also find the following key facts, based on the evidence of the Superintendent's two witnesses, Mr. Vishal Batta and Mr. Sean Mitchell, the evidence of Dr. Ryzhykh, and the Agreed Book of Documents:

a) Dr. Ryzhykh practices as a registered chiropractor.

b) Mr. Vishal Batta, a Senior Compliance Officer (the "Compliance Officer") with the Market Conduct Compliance Unit at the Financial Services Commission of Ontario ("FSCO"), attended at the South Barrie clinic on October 26, and November 9, 2016. He performed limited scope on-site examinations of South Barrie's billing practices, business systems and practices, including established and implemented policies and procedures. In connection with the examinations, Mr. Batta sampled five specific files and found irregularities in at least two of them.

c) There were two OCF-21s, or Auto Insurance Standard Invoices, (the "Invoices") included in the Book of Documents in which irregularities were discovered by the Compliance Officer: we will refer to these as the Commonwell Invoice and the Peel Invoice. Definitions and other information respecting these two Invoices is set out below.

d) **Commonwell Invoice** - During the examination, the Compliance Officer observed an OCF-21 dated February 11, 2016 submitted by South Barrie to The Commonwell Mutual Insurance Group (the "Commonwell Invoice") for chiropractic and massage therapy treatment sessions. These sessions were performed pursuant to an approved OCF-18 (a Treatment and Assessment Plan) for a specific individual (the "Patient"). We were advised, and there was no evidence to contradict it, that there were inconsistencies between the calendar kept by the clinic and the Invoice. We note that excerpts from the calendar were not submitted into evidence. The Invoice billed for two chiropractic sessions that were not shown in the calendar. Mr. Batta claimed that there were other irregularities with the Invoice. We will address those irregularities below, in Part V – The Positions of the Parties and Analysis.

e) Included in the Agreed Book of Documents was an excerpt from a sign-in sheet for the Patient. This sheet did not include sign-in and sign-out times but it did show that the Patient had received chiropractic sessions on the two occasions where the calendar did not include a chiropractic session.

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f) **Peel Invoice** - Also during the examination, the Compliance Officer observed an OCF-21 dated June 21, 2016 submitted by South Barrie to Peel Mutual Insurance Company (the "Peel Invoice") for certain treatment sessions pursuant to an approved OCF-18. The Invoice was signed by Dr. Ryzhykh and billed for a number of treatment sessions rendered by Dr. Ryzhykh, and a number of treatment sessions allegedly rendered by Mr. P. The sessions rendered by Mr. P were indicated to have taken place between April 7, 2016 and June 21, 2016, which was subsequent to the termination of Mr. P's employment at the clinic.

g) Included in the Book of Documents at Tab 7 was a DVD with additional information for the Tribunal to consider. This information included detailed notes taken during the examination relating to the five sampled files. Superintendent's counsel drew the Tribunal's attention to two specific entries from excerpts taken from the DVD material and entered separately into evidence. One of the entries was in respect of the Commonwell Invoice, as follows: "I was told by Chiro the appointment calendar was still new and I should go by signing sheet. Later, on December 13, 2016 I called Mira to reconfirm how good the appointment calendar is and she said it can be fully trusted". It was not confirmed in evidence brought to our attention at the hearing, but we understand that Mira was the clinic administrator at that time (the "Clinic Administrator").

h) The Tribunal's attention was also drawn to a comment respecting the Peel Invoice. The following is noted: "[Principal Representative] claimed this was an error and he had notified the physiotherapist of this error. I told him that I accept this is an error, but still it was violation as he signed OCF 21 himself and it should be verified before it is submitted". [Emphasis added]

i) Exit Meeting Notes were prepared by the Compliance Officer and signed by him and Dr. Ryzhykh. The specific Invoices are not mentioned in these Notes. However, the below quoted comments, under columns titled "Issues Noted" and "Remedial Plan", appear to be made in respect of the following Invoices:

   i. **Commonwell Invoice** – Issues Noted: "Healthcare Service Provider is charging maximum hourly rate for chiropractic/massage treatment but providing only half an hour treatment to the patient as verified from the appointment calendar". Remedial Plan: "Healthcare Service Provider should take reasonable steps to ensure that the invoices are submitted based on the rates prescribed under Professional Services Guideline with proper disclosure of actual duration of services provided to the patient."

   ii. **Peel Invoice** – Issues Noted: "OCF 21 form was incorrectly submitted by PR under physiotherapist after he left the facility for the services not provided by physiotherapist". Remedial Plan: "Service Provider should not submit invoice with inaccurate or false information."

IV. STATUTORY FRAMEWORK

[8] Section 439 of the Act indicates, "No person shall engage in any unfair or deceptive act or practice."

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[9] Subsection 3(1) of Ontario Regulation 7/00 (the "Unfair or Deceptive Acts or Practices Reg"), reads as follows:

> "For the purposes of the definition of "unfair or deceptive acts or practices" in section 438 of the Act, each act and omission listed in subsection (2) is prescribed as an unfair or deceptive act or practice if it is committed by or on behalf of a person with the expectation that a benefit will be received that is funded, directly or indirectly, out of the proceeds of insurance."

[10] Paragraph 1 of subsection 3(2) of the Unfair or Deceptive Acts or Practices Reg lists the following as one of the acts to which reference is made in the excerpt from subsection 3(1) set out in paragraph [9] above:

> "Charging an amount in consideration for the provision of goods or services to or for the benefit of a person who claims statutory accident benefits or who otherwise claims payment under a contract of insurance, <u>if the goods or services are not provided</u>." [Emphasis added]

[11] Therefore, the Superintendent has the burden of proving that the services were not provided.

V. THE POSITIONS OF THE PARTIES AND ANALYSIS

[12] In his written submissions, Superintendent's counsel would have us find that South Barrie contravened the Act by engaging in two instances of unfair or deceptive acts or practices, and, in particular, that South Barrie twice charged an amount in consideration for the provision of goods or services to or for the benefit of a person who claims statutory accident benefits or who otherwise claims payment under a contract of insurance, where the goods or services were not provided.

[13] The Superintendent has submitted evidence of inconsistencies between the OCF-21 forms that were filed with two insurance companies and the appointment calendar kept on the premises at South Barrie. In respect of the Commonwell Invoice, the Superintendent has shown inconsistencies between the Invoice and the calendar with respect to the scheduling of chiropractic services. With respect to the Peel Invoice, the Superintendent has shown that the Invoice identified a physiotherapist having performed services at a time subsequent to the termination of employment of that physiotherapist.

[14] The analysis in respect of the Peel Invoice is more straightforward. We have found as a fact that Mr. P was listed on the Invoice as providing services and it is clear that he did not actually provide those services, as he had left the clinic by that time.

[15] Dr. Ryzhykh admitted to submitting the Peel Invoice with this inaccuracy but indicated that it was submitted in error. In the Tab 7 materials discussed above, the Compliance Officer accepted that it was an error. Dr. Ryzhykh indicated that it was based on the Treatment and Assessment Plan, which had been put together months previously and had not initially been approved by the insurance company. When the plan was finally approved either Dr. Ryzhykh or the Clinic Administrator would have pulled up the form, clicked on the dates the services were provided, saved it, signed it and sent it to the insurance company. The service provider expected to have completed the services (Mr. P) was not changed but the services had been

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performed. Dr. Ryzhykh indicated that he had performed the services, and we found his evidence persuasive.

[16] The inaccuracies with respect to the Commonwell Invoice are more complex. We have found as a fact, that the Commonwell Invoice charged for two chiropractic sessions that were not listed in the calendar. However, there was a sign-in sheet that showed the sessions had occurred on those days. In those cases, there is evidence that the services were provided.

[17] In addition to those two chiropractic sessions, the Superintendent, through the documentation and one of his witnesses, submitted there were additional inaccuracies in the Commonwell Invoice. There was one chiropractic session which was billed at one hour whereas the calendar showed that particular session lasted only half an hour. In addition, the Compliance Officer noted that there were two dates where a one-hour massage session was charged on the Invoice, but the calendar only showed half hour sessions booked for those two dates.

[18] This requires us to find that the Invoice actually listed how long the sessions lasted.

[19] Little evidence was elicited at the hearing, and no direct submissions were made by counsel for the Superintendent to assist the Tribunal in understanding some of the information on the Invoices, including information set out under columns titled "Code", "Quantity", "Measure" and "Cost". We note that on the two OCF-21s included in the Book of Documents, Quantity was always shown as "1.00" or "1", "Measure" was shown as either "PR" or "HR" and on the Commonwell Invoice the cost shown differed significantly, from $50.00 up to $112.81, whereas, on the Peel Invoice, the cost was consistently $112.81.

[20] We note this because it was not clear to the Tribunal that when "Quantity" was indicated as "1.00" it related to an hour of services. In his testimony, Dr. Ryzhykh explained the day-to–day workings of the clinic. He indicated that there are no legislative rules requiring a daily calendar kept at a clinic to be fully accurate. According to Dr. Ryzhykh, the calendar changes frequently, and no final version is prepared at the end of the day. It is just meant to provide an idea of what the day will look like. Some patients miss appointments, other patients decide to have a further treatment while they are there. Some patients are squeezed in, on an emergency basis.

[21] In addition, according to Dr. Ryzhykh, there is no way to be exact in calculating how long a session will take. In fact, there is no need to keep track of exactly how long a session has taken, as many people are just charged the "base" rate. No evidence was led as to how much was charged by the clinic for one hour versus 30 minutes of chiropractic or massage therapy. An hourly basis did not seem to be the basis on which services were charged. There was also no detailed explanation of how the base rate might change depending on the provider or the services provided.

[22] Evidence was entered, both in hard copy and orally, respecting the comments of South Barrie's Office Administrator as to the accuracy of the Calendar. We find this to be of little value, considering the remainder of our analysis in this Part V.

[23] Included in the Book of Documents at Tab 12, was a document titled "Ontario Chiropractic Association OCA Recommended Service Codes and Fee Schedule". No detailed comments were made respecting this document and why it was included in the Book of Documents, however, we note on page 2, under the heading "Fees are Recommendations" it is

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indicated as follows: "The Fee Schedule is issued for information purposes only. Adoption of the recommended fees remains at the discretion of the practitioner. The Ontario Chiropractic Association does not set fees for chiropractors". [Emphasis added]

[24] This seems to be at odds with the Remedial Plan suggested by the Compliance Officer in respect of the Commonwell Invoice, which we repeat here: "Healthcare Service Provider should take reasonable steps to ensure that the invoices are submitted based on the rates prescribed under Professional Services Guideline with proper disclosure of actual duration of services provided to the patient." However, we will not say more on this issue as the note does not clearly indicate to which Professional Services Guideline it is referring, nor does it clearly indicate to which services it is referring.

[25] Based on the above, it does not seem possible, without more information, to make a determination as to how much time was spent on the particular chiropractic and massage patient in question, just by the amount he or she was charged for the service as indicated on the Commonwell Invoice.

[26] We are not able to assign any particular significance to the fact that the Exit Meeting Notes of the Compliance Officer were signed by Dr. Ryzhykh. No submissions were made specifically on this point and no oral evidence was provided to us to assist our understanding. Therefore, we make no findings on this point.

[27] The "Issues Noted" on the Commonwell Invoice indicated that the Service Provider was charging a maximum hourly rate, but providing only a half hour treatment. As adoption of the OCA recommended fees is at the discretion of the practitioner, and, further, as it is not clear to us that the Commonwell Invoice indicates hourly sessions, we cannot find either that the Service Provider was charging the maximum rate or that the length of the actual sessions differed from what was shown on the Invoice.

[28] Superintendent's counsel spoke briefly to the contraventions themselves and referred us to his written submissions for the legal argument. He initially argued that we should find that the services were not provided based on the inconsistencies in the paperwork. However, on several occasions it appeared as if counsel was admitting that the services may have been performed but asking us to impose the penalty because of the errors made in the paperwork. On one occasion, when asked by a member of the Tribunal, Superintendent's counsel replied, in respect of the Peel Invoice, that it was immaterial if Dr. Ryzhykh provided the services. He indicated that South Barrie should be penalized if the Invoice stated that Mr. P provided the services when he did not do so.

[29] This understanding seems to be corroborated by the evidence given by Mr. Sean Mitchell, a Regulatory Discipline Officer with FSCO, who also provided evidence with respect to his involvement with the health service provider licensing regime, and his involvement with providing instructions with regard to the drafting of the NOP in this case. He was involved with reviewing the evidence and determining whether a contravention had occurred. In his oral evidence, Mr. Mitchell indicated that the professional signing the invoices must ensure that all submissions are accurate, and since these submissions were not accurate, there were contraventions of the Act.

[30] The Superintendent included in its Book of Authorities, the Supreme Court of Canada decision in, *La Souveraine, Compagnie d'assurance générale v. Autorité des marchés financiers* 2013 SCC 63 (the "SCC Decision"). The Tribunal asked if its attention was intended

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to be brought to section 49 of that decision, which reads, in part, "…Those who engage in regulated activities agree in advance to adhere to strict standards, and they accept that they will be rigorously held to those standards, which are typical of such spheres of activity. It is therefore not surprising in the regulatory context to find strict liability offences…", and the Superintendent's counsel confirmed that it was.

[31] However, we note another excerpt from the SCC Decision that is relevant to the decision we have before us. Section 55 of the SCC Decision states that, "…the offence provided for…is one of strict liability. Once the *actus reus* has been proved beyond a reasonable doubt, the defendant can avoid liability only by showing that it acted with due diligence."

[32] In our view, we first need to determine if the *actus reus* has been proved. In criminal matters *actus reus* is often understood to mean "guilty act". Under the current circumstances we can consider it to refer to the "prohibited act". It is prohibited to charge an insurance company for services which are not provided. In this case, the Superintendent has the burden of proving that the services were not provided.

[33] Based on the evidence, the Superintendent has not been successful in proving that the services listed in the Commonwell Invoice and the Peel Invoice, that Dr. Ryzhykh claims his clinic has provided, were not provided.

[34] It is unnecessary to comment in these Reasons on whether the appropriate test is "beyond a reasonable doubt" or "on a balance of probabilities" as on either scale the contravention of the Act has not been proved. We have looked at the evidence before us and cannot conclude that it proves South Barrie engaged in the unfair or deceptive act or practice specified in paragraph 1 of subsection 3(2) of the Unfair or Deceptive Acts or Practices Reg.

[35] Pursuant to subsection 441.3(6) of the Act, when the Tribunal has held a hearing following a notice of proposal to impose an administrative monetary penalty, the Tribunal may, by order, direct the Superintendent to carry out the proposal, with or without changes, or substitute its opinion for that of the Superintendent.

VI. ORDER

[31] For the foregoing reasons, the Tribunal hereby directs the Superintendent, by order, not to carry out his proposal to impose an administrative monetary penalty of $4,000 on the Applicant, 1631776 Ontario Inc., operating as South Barrie Health Group.

Dated at Toronto, this 25th day of April, 2018.

"Bethune Whiston"
Bethune Whiston

"Jill Wagman"
Jill Wagman

2018 ONFST 7 (CanLII)

"Christopher Portner"
Christopher Portner

2018 ONFST 7 (CanLII)

In the end, these audits drained time and money from everyone involved. Healthcare professionals were left frustrated, while auto insurance consumers saw no real benefit.

SECTION 2:

A response to the Statutory Accident Benefits Schedule (SABS) Guidelines Review

If you're headed for a brick wall, don't keep going

October 2024

Foreword

As a healthcare professional, responding to this consultation document has been particularly challenging. Healthcare professionals—whether physiotherapists, chiropractors, physicians, nurses, or massage therapists—identify deeply with our professions. When asked what we do, we don't just mention where we work; we say, "I am a physiotherapist," or "I am a healthcare professional." This isn't just a job to us; it's a fundamental part of who we are, we identify as our profession.

When I read sections of this consultation that felt reductive or dismissive, it was a personal affront. So, I had to remind myself that even though the words are in English we're not speaking the same language. I am hoping to bridge the divide between the language of healthcare and the language of financial services.

In healthcare we view rehabilitation as a "benefit", yet financial services view rehabilitation expenses as a "medical loss". The terms used work against us to find the common ground and the best measurement of success.

For those of us dedicated to caring for others, particularly within the regulated healthcare professions, this language hits differently. Reading a justification that essentially says, "We didn't have to review your rates; we weren't legally required to,"—especially after two decades of stagnant remuneration, while we manage the daily complexities of caring for accident victims—felt like a slap in the face. While I'm sure this wasn't the intention, it felt unnecessary to even state

I shared this section of the consultation with professional colleagues, and they all immediately understood the frustration. However, those outside of healthcare did not fully grasp how deeply we connect with both our patients and our profession and did not feel the same.

This experience has made it clear to me that, despite nearly a decade of licensing healthcare professionals, financial services regulators like FSRA still do not truly understand the very personal nature of our work. The consultation wording, and the creation of a licensing system focused on arbitrary bureaucratic requirements, is harmful to professionals who are already self-regulated and to patient care itself, yet this may not be easily understood by people who are not regulated healthcare professionals.

FSRA seems unaware of the deep commitment and care required of ourselves to help others and to practice our profession effectively.

Reading these consultations crystallized for me why financial services regulators should not be redundantly licensing healthcare professionals. It's not because they aren't good people, it's because it's a completely different frame of mind.

Financial services have never once reached out to healthcare professionals to ask, "What are we doing wrong in auto insurance treatment?" They've shown no interest in understanding the challenges of delivering healthcare or how their rules are actually causing treatment failures and driving up costs.

Of course, we know that most people are good, we help them every day. Yet the unyielding box ticking framework of HSP licensing isn't a good for regulated healthcare professionals.

Regulatory healthcare colleges, as more specialized agencies, are far better equipped to balance the unique demands of patient care with appropriate regulation that focuses on ethical behaviour without harming the care professionals provide.

Although the language in this consultation was likely not meant to be mean-spirited, it reveals a disconnect and why FSRA may not be best suited to license healthcare professionals. The consultation and market conduct reports highlight this disconnect.

Regulators who oversee any aspect of our profession need to truly comprehend what we do, how deeply we care, and the personal nature of our work. This process has solidified my view that the HSP licensing system is not only redundant for clinics owned by regulated healthcare professionals but is also harmful to both the professionals and the care they provide, ultimately not serving the best interests of patients.

It has also solidified my view that these perceptions are a hurdle in creating SABS policies that benefit the consumer. We are looking at the same problems from different perspectives, and while our respective views feel valid, the truth likely lies somewhere in between. We need to collaborate to find a streamlined, efficient path forward that benefits consumer and achieves the objectives of these SABS consultations.

While participating in this consultation has been challenging, I remain committed to the process. As a healthcare professional, I will continue to advocate for a system that supports sustainable, effective care for my patients and upholds the standards of our profession.

Today's MIG, PSG, and Attendant Care Issues Explained Simply

Imagine you're given fifty dollars for gas and told to make it last for an entire month of driving. Fifteen years ago, maybe that would have gotten you through – just barely.

Now imagine your given fifty dollars today to make it through an entire month. With today's prices and the higher cost of living, fifty dollars barely gets you through a week, let alone a month.

This is exactly what healthcare providers and patients face with the unchanged Minor Injury Guideline (MIG), unchanged Professional Services Guideline (PSG), and unchanged attendant care limits.

The "budget" from years ago remains the same, while costs and patient needs have only grown. Just as fifty dollars of gas no longer gets you where you need to go, these outdated guidelines and limits prevent healthcare professionals from providing the level of care patients require, leaving everyone stuck far short of the destination.

Healthcare professionals are unable to bring people to their desired destinations, back to work, back to function, yet those are the goals of our accident benefits system and that is what is being asked of us.

Context and Considerations

A Welcome Review: Collaborating for Better Patient Care

Healthcare professionals who treat individuals involved in car accidents are facing significant challenges. I welcome this timely review and greatly appreciate the Ministry of Finance's commitment to addressing these important issues. This consultation presents an opportunity for collaborative efforts to enhance the auto insurance system for the benefit of all stakeholders.

Challenges in Compensation and Administrative Processes

Within the auto insurance treatment framework, compensation for healthcare services remains lower than it was nearly three decades ago. Current remuneration is less than it was in 1996, a result of policies that haven't adjusted for inflation or the true complexity of treating accident victims. Healthcare professionals often find themselves in a difficult position: either eliminate their participation in the auto treatment framework or provide care at rates that challenge both patient outcomes and professional sustainability.

Additionally, issues such as significant administrative burdens, cumbersome invoicing processes, and redundant licensing requirements affect both healthcare providers and patients.

Despite fewer accidents each year, consumers of auto insurance are not receiving optimal value for their premiums, which is a concern I believe can be addressed through collaborative efforts. The auto insurance framework has seen a significant increases in spending on disputes, settlements, and the administrative burden that comes with red tape and dueling assessments yet direct treatment of patients from healthcare professionals is effectively decreasing due to inflation.

Impact on Patient Care and Public Health

These challenges have significant consequences for patient care. Within managed care frameworks such as the PAF and now the MIG, patients do not receive the comprehensive treatment they need for proper recovery, leading to an offloading of costs onto public healthcare system for long-term management of chronic pain. This often involves the use of opioids and government-funded chronic pain clinics, contributing to increased healthcare costs and societal impacts. Research indicates that chronic pain is three times more costly to society and the economy than all cancers combined.

> In Ontario: **chronic pain is three times more costly to the economy than all cancers combined.**

I see this consultation as a timely opportunity to prevent further strain on the auto insurance framework and improve real outcomes that can create a sustainable fair auto insurance framework. By focusing on intelligent design and systemic improvements, we can lower long-term costs for consumers while ensuring the availability of quality services and sustainable insurance practices.

Embracing Collaborative Solutions for Systemic Improvement

For the past 20 years, discussions about auto insurance reform have often prioritized controlling premiums over investing in patient care and long-term solutions. While controlling premiums is important, I believe that a broader, more holistic approach will yield better outcomes for all.

This approach seems to have been mandated by previous governments and the bureaucracy has been singularly focused on the performance indicator "insurance premiums" to the detriment of long-term savings.

Investing in healthcare upfront—much like removing red tape—may increase immediate costs but we know it leads to significant long-term savings. By improving patient health outcomes post-accident through properly funded care, we can reduce long-term disability, lessen the burden on public healthcare, and decrease the overall need for costly legal settlements. Adopting a LEAN approach allows us to streamline processes, eliminate inefficiencies, and focus on value-driven improvements that enhance patient outcomes and ensure the sustainability of the auto insurance system.

I appreciate the wisdom in the prudent and balanced path outlined in the March 2024 budget, which called for a review and anticipated efficiencies within the system. This demonstrates a commitment to thoughtful reform, and I am hopeful that through collaborative efforts, we can achieve meaningful improvements.

Understanding Historical Context and the Need for Change

It's important to consider the historical fee reductions and the impact of the Minor Injury Guideline (MIG). In 1996, the fee for a healthcare session was up to $120 (it was not left to the market as noted on page 6), it was reduced to $84 per hour, and today remains at $99.75 per hour. The introduction of the MIG, which limits compensation for clinics to $200 for a four-week block of treatment, has further challenged the ability of healthcare professionals to provide adequate care.

We recognize that policies may not have kept pace with the evolving needs of patients and providers. By addressing these issues collaboratively, we can work toward a compensation framework that reflects the true value of healthcare services and supports optimal patient recovery.

Positive Outcomes Through Collaborative Efforts

As healthcare professionals, we witness the effects of underfunding firsthand: challenges in patient outcomes, increased reliance on public welfare systems like the Ontario Disability Support Program (ODSP), and increased use of publicly funded chronic pain programs. Formerly productive individuals injured in motor vehicle accidents may become dependent on support programs due to inadequate care received post-accident. By prioritizing patient recovery through adequate care, we can help individuals return to their productive roles in society, reducing long-term costs and improving overall well-being.

Aligning the Financial Services Regulatory Authority's (FSRA) approach with a focus on long-term benefits will serve the insurance consumer and public interest. By considering the broader impacts of investing in healthcare services, we can achieve better health outcomes for accident victims and contribute to a more sustainable system.

Addressing administrative burdens is also crucial. While fewer accidents are occurring, increased paperwork, legal disputes, and inefficiencies drive up costs for consumers. By working together to streamline processes and reduce inefficiencies, we can lower costs and improve the experience for healthcare providers and patients alike.

Emphasizing the Importance of Fair Remuneration and System Efficiency

The consequences of a mandated siloed approach with a singular focus on auto rates has resulted in another systemic problem. The omission of adjusting the Health Tax Levy, which has remained unchanged since 2006.

The Auditor General of Ontario has recommended updating the levy to align with current healthcare expenses. A modest increase—such as $20 per vehicle annually—could generate an additional $200 million for emergency rooms and healthcare services, benefiting both the public and insurers.

SABS Medical Rehabilitation Goals:

> ***Auto insurance isn't worth the paper it's written on if it's just an empty promise.***
>
> *Instead of zeroing in on premiums as the main concern, we need to focus on what truly matters:*
> *-**shorter disability durations**,*
> *-**better return-to-work rates, reduced reliance on pain management,***
> *-**lower rates of chronic conditions and mental health issues**, and*
> *-**easing the strain on families and social support systems**.*
>
> *If these outcomes are overlooked, then no premium—no matter how low—has real value.*

Disputes between insurer and an insured regarding the provisions within the SABS occur due to different expectations of what the goals of rehabilitation care should be. This type of dispute does not occur in other rehabilitation frameworks such as OHIP, WSIB or EHB.

Regulated healthcare professionals define 'reasonable and necessary' in relation to the stated goals or purpose of the rehabilitation benefits. For example, in WSIB programs of care (akin to the minor injury guidelines), these goals are straightforward, primarily aimed at returning to work on modified duties – there is no expectation of a full injury recovery.

However, the SABS outlines broader goals for rehabilitation benefits: reducing or eliminating the effects of any disability resulting from impairment, and facilitating the person's reintegration into their family, society, and the labour market. Therefore, what is 'reasonable and necessary' within the context of the SABS becomes considerably more complex and involves more intervention than in simpler frameworks.

Disputes frequently arise when professionals feel that insurance companies are not adhering to these broader goals stated in the SABS, leading to differing interpretations of 'reasonable and necessary' and insurers feel the patient does not require the requested care.

Regulated Healthcare professionals rely on the following sections of the SABS to submit treatment programs:

Rehabilitation benefits

16. (1) Subject to section 18, rehabilitation benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person in undertaking activities and measures described in subsection (3) that are reasonable and necessary for the

purpose of reducing or eliminating the effects of any disability resulting from the impairment or to facilitate the person's reintegration into his or her family, the rest of society and the labour market. O. Reg. 34/10, s. 16 (1).

(2) Measures to reintegrate an insured person into the labour market are considered reasonable and necessary, taking into consideration the person's personal and vocational characteristics, if they enable the person to,

(a) engage in employment or self-employment that is as similar as possible to the employment or self-employment in which he or she was engaged at the time of the accident; or

(b) lead as normal a work life as possible. O. Reg. 34/10, s. 16 (2).

These extremely broad and appropriate purposes are the source of disputes between an insurer and an insured. We do not want accident injuries to become a pathway to a reliance on social welfare.

Statutory Accident benefits define rehabilitation as:

Rehabilitation benefits

16. (1) Subject to section 18, rehabilitation benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person in undertaking activities and measures described in subsection (3) that are reasonable and necessary for the purpose of reducing or eliminating the effects of any disability resulting from the impairment or to facilitate the person's reintegration into his or her family, the rest of society and the labour market. O. Reg. 34/10, s. 16 (1).

(2) Measures to reintegrate an insured person into the labour market are considered reasonable and necessary, taking into consideration the person's personal and vocational characteristics, if they enable the person to,

(a) engage in employment or self-employment that is as similar as possible to the employment or self-employment in which he or she was engaged at the time of the accident; or

(b) lead as normal a work life as possible. O. Reg. 34/10, s. 16 (2).

(3) The activities and measures referred to in subsection (1) are,

(a) life skills training;

(b) family counselling;

(c) social rehabilitation counselling;

(d) financial counselling;

(e) employment counselling;

(f) vocational assessments;

(g) vocational or academic training;

(h) workplace modifications and workplace devices, including communications aids, to accommodate the needs of the insured person;

(i) home modifications and home devices, including communications aids, to accommodate the needs of the insured person, or the purchase of a new home if it is more reasonable to purchase a new home to accommodate the needs of the insured person than to renovate his or her existing home;

(j) vehicle modifications to accommodate the needs of the insured person, or the purchase of a new vehicle if it is more reasonable to purchase a new vehicle to accommodate the needs of the insured person than to modify an existing vehicle;

(k) transportation for the insured person to and from counselling and training sessions, including transportation for an aide or attendant; and

(l) other goods and services that the insurer agrees are essential for the rehabilitation of the insured person, and for which a benefit is not otherwise provided in this Regulation, except,

(i) services provided by a case manager; and

(ii) housekeeping and caregiver services. O. Reg. 34/10, s. 16 (3); O. Reg. 251/15, s. 6.

(4) Despite subsection (1), the insurer is not liable to pay rehabilitation benefits,

(a) for expenses related to goods and services described in subsection (3) rendered to an insured person that exceed the maximum rate or amount of expenses established under the Guidelines, other than for expenses related to the services described in clause (3) (k);

(b) for expenses incurred to renovate the insured person's home if the renovations are only for the purpose of giving the insured person access to areas of the home that are not needed for ordinary living;

(c) for the purchase of a new home in excess of the value of the renovations to the insured person's existing home that would be required to accommodate the needs of the insured person;

(d) for expenses incurred to purchase or modify a vehicle to accommodate the needs of the insured person that are incurred within five years after the last expenses incurred for that purpose in respect of the same accident;

(e) for the purchase of a new vehicle in excess of the amount by which the cost of the new vehicle exceeds the trade-in value of the existing vehicle;

(f) for transportation expenses other than authorized transportation expenses. O. Reg. 34/10, s. 16 (4); O. Reg. 14/13, s. 2.

For reference the minor injury guideline– is based on a functional restoration model of care.

Whereas a Functional restoration model of care is not necessarily meant to fully resolve an injury on its own, but rather it is designed to help individuals improve their functional abilities and overall quality of life. Many insurance professionals have a false idea that a functional restoration model of care is supposed to result in a full resolution.

> Essentially, the goal of the MIG is not necessarily to completely resolve the injury in 12 weeks but rather to provide your client with the knowledge, education, and strategies to help them return to full function within a reasonable amount of time. – the MIG program was not reasonable to achieve the goals of the SABS as a stand-alone program 10 years ago. https://www.canadianunderwriter.ca/features/cc-minor-injury-guideline-refresher/

Rehab or Just a Price Cap? The Real Cost of Cutting Corners in Injury Recovery

There's a fundamental disconnect between the goals of the Statutory Accident Benefits Schedule (SABS) and how insurers and financial services are handling rehabilitation benefits. The SABS was created to support full rehabilitation, aiming to reduce disability, restore function, and help people rejoin work, family, and community life as independently as possible. It includes a wide range of services—from counselling to home modifications—to help achieve this.

However, insurers often push a functional restoration model, which doesn't aim to resolve injuries fully but merely to restore basic function. Many mistakenly think this model leads to full recovery, but in reality, it's limited. Frameworks like the Minor Injury Guideline (MIG) are promoted as treatment models, yet they're essentially fee caps designed to limit insurer costs, pushing much of the long-term recovery burden onto the public healthcare system.

This creates a gap: the legislation promises comprehensive support, but in practice, these "treatment" frameworks mostly contain costs rather than ensuring recovery. If we continue to ignore this, people will keep falling through the cracks, left to rely on social services and the public health system for care that insurers should be providing.

Relevant Information

Effects of Poor Remuneration on Consumer Benefits

The current rate for physiotherapy under the Statutory Accident Benefits Schedule (SABS) is approximately $99.75 per hour. As highlighted in the consultation document, stakeholders have expressed that this rate does not adequately cover the costs of providing high-quality care, including charting, overhead, and equipment expenses. In contrast, tradespeople such as plumbers, electricians, and HVAC technicians earn around $195 per hour—nearly double the rate paid to physiotherapists.

These inadequate fees, whether within the Minor Injury Guideline (MIG) or Pre-Approved Framework (PAF), force healthcare providers to see more patients simultaneously to cover fixed costs. This limits the time professionals can dedicate to each patient, compromising care and leading to incomplete recoveries. The burden of excessive red tape and administrative tasks further exacerbates this issue. In effect consumers receive less value for their dollar.

Patients who do not receive the necessary intensity and duration of rehabilitation are at greater risk of developing chronic conditions, increasing their long-term dependency on the healthcare system. While this may not be a direct concern for insurance companies, who can settle claims and therefore are no longer in the picture, chronic pain costs the economy three times more than all cancers combined. The accident benefits system should prioritize getting people back to work and preventing the development of chronic pain to avoid offloading these patients onto programs like ODSP.

To make matters worse, the low fees have driven many skilled healthcare providers out of Ontario in search of jurisdictions where their work is appropriately valued and compensated. This exodus has reduced the patient access to qualified professionals, further compromising the quality of patient care.

The Flawed Argument: "If We Increase Treatment Rates, Insurance Premiums Will Go Up"

The Insurance Bureau of Canada economist Jack Mintz of the School of Public Policy at the University of Calgary has stated that rate caps lead to higher prices in the long term, primarily due to the instability created when companies can't earn profits sufficient to maintain capital investment. This argument was used by insurers in Alberta but also apples to rehabilitation services.

If companies can't invest in their operations due to reduced profits, they become less financially stable, which could lead to long-term price increases as they eventually need to recoup costs or find ways to increase profitability once the caps are removed or adjusted. This situation creates a **cycle of inefficiency** that can make treatment more expensive in the future.

Additionally, if I view rehabilitation treatment, which helps a person return to work and become a productive member of society, as merely an 'expense' or a 'medical loss,' it's understandable that I would want to minimize those costs to keep auto insurance rates low for consumers.

Since 2003 previous governments have imposed a primary performance indicator of "**low rates**" as a measure of success upon the insurance regulator. One government famously stated they would reduce rates by 15% and later backtracked on that stating it was a "stretch goal".

The strategy of controlling costs by setting artificially low maximum PSG rates has backfired. By undervaluing healthcare services, the FSRA is driving providers out of the jurisdiction, and this results in worsening access to care are poorer outcomes due to decreased efficiency. I am pleased to see the Ministry of Finance has ordered a review of the guidelines to ensure the continued availability of services in the MVA framework and to also prevent the loss of private clinic services to other funding frameworks as well.

Manipulating a marketplace is harmful, it distorts natural supply and demand dynamics, leading to inefficiencies and imbalances. When prices, services, or access are artificially controlled, it discourages competition and innovation, ultimately reducing quality and choice for consumers. Over time, these distortions create consolidation and monopolies or drive businesses to exit the market, limiting supply and increasing costs. In the healthcare sector, for example, results in reduced access to care, higher expenses for both the public and private sectors, and an overburdened system that fails to meet the needs of patients effectively. Sustainable economic growth and a healthy marketplace rely on fair competition and transparency, which benefit both consumers and providers in the long run.

Raising the Professional Services Guidelines (PSG) rates is often opposed due to concerns that it would increase insurance premiums. However, this argument is short-sighted. Ensuring full recovery for patients requires appropriate compensation for the rehabilitation providers and is far more cost-effective in the long run, as it reduces reliance on public healthcare and social welfare systems, while also lowering settlement, claim management, and administrative costs.

Proper fees increase system efficiency and improves patient outcomes.

Failing to provide adequate care leads to greater long-term societal costs, including chronic pain management, disability support, and a reduced workforce. These additional burdens fall on public healthcare and innocent taxpayers, as the current system offloads costs from private insurers to the public sector.

As a thought experiment, imagine applying the same approach to executive compensation. Capping FSRA and insurance company executives' salaries at 1996 levels would seem unimaginable and unfair today—yet this is exactly what has been done to healthcare professionals in Ontario. Nearly 30 years ago, their fees were slashed, and they remain stagnant, despite rising costs and increased demands. It's unjust to expect healthcare professionals to bear the burden of outdated compensation rates, and I am grateful for this review. This inequity must be addressed to ensure fairness for all those involved in the auto insurance system.

I believe a futur state of SABS requires the FSRA to do better in tracking recoveries and return-to-work outcomes going forward. The emphasis on "low rates" rather than patient recovery has resulted in poorly monitored recovery rates, leading to suboptimal outcomes and increased societal costs finally it isn't working since auto insurance costs continue to rise.

The Need for FSRA to Encourage Insurer Efficiencies

Yet choosing the correct performance indicator is not the only suggestions that we should embrace. FSRA should focus on encouraging insurance companies and all stakeholders to find efficiencies rather than manipulating the market through artificially low compensation rates. The current approach stifles innovation and fails to incentivize improvements in care delivery. By prioritizing efficiency over market control, FSRA can help create a more sustainable system that benefits both healthcare providers and patients, ensuring better care while managing costs effectively by.

The Need for FSRA to Ensure Fines and Penalties are Not Passed onto Consumers

I believe there is a need for FSRA to ensure that fines and penalties are not passed on to consumers. One way to address this could be to require that fines and penalties are noted as a reserve in insurers' financial statements, ensuring they are handled appropriately without impacting consumer rates and excluded from ratemaking calculations.

What's the point of a fine if it can simply be passed along to consumers through higher premiums, turning penalties into a profit centre? The FSRA should ensure that fines and penalties aren't offloaded onto consumers. Require insurers to reserve these penalties in their financial statements and exclude them from rate calculations. But here's the catch: the FSRA doesn't demand this level of detail, so no one's actually checking if it's done right. Why not?

Worth Repeating: If Costs Go Up, Won't Auto Insurance Premiums Will Go Up Too!!

Physiotherapy is part of primary care; in auto insurance we are attempting to save money but are only increasing our downstream costs.

The root of the problem lies in FSRA's approach, shaped by legislation from 2003, which ties their key performance indicator (KPI) almost exclusively to keeping auto insurance premiums low. However, this focus misses the mark because our rates are anything but low. In fact, they're significantly higher than in many other jurisdictions, including American ones with much more litigation. Despite these higher premiums, consumers aren't getting good value for their money, and the system fails to prioritize the needs of accident victims. To fix this, we need a system that addresses **real out of control cost drivers** (such as admin burden, redundant systems and red tape) and allows for treatment rate increases that support better, more sustainable care for those who need it.

This common argument overlooks the bigger picture. FSRA's focus on keeping auto insurance premiums low, driven by their key performance indicator (KPI), often sacrifices long-term solutions that could improve patient outcomes. When decisions are made with short-term costs in mind, more expensive but effective treatment options are dismissed, even though they can lead to better, long-term recovery for accident victims.

The idea that raising rates will automatically hike premiums needs a common-sense review. The real issue isn't just about treatment costs—it's about **addressing the true cost drivers** in the system, like administrative inefficiencies, duplicated assessments, and prolonged disputes. If we focus on fixing these systemic issues and allow for rates that reflect the true costs of care, we'll promote sustainable treatment for accident victims without the knee-jerk fear of rising premiums.

The Complexity of Treating Car Accident Injuries

Treating car accident patients within the accident benefits framework is not only more expensive due to redundant licensing requirements and associated annual fees, but it also involves significantly more unpaid touchpoints and interactions. Healthcare providers must frequently engage with insurers, lawyers, and care administrators, while navigating a complex system that requires extensive handholding of patients through forms, attestations, and other administrative hurdles.

Car accident injuries are also inherently more complex than simple, isolated injuries. These injuries often involve multiple areas of the body, such as the neck and shoulder, which are interconnected and require more feedback with the patient, for example, treating a neck injury can exacerbate shoulder pain, and vice versa, necessitating careful coordination between different treatment modalities.

The nature of car accidents results in injuries that are more complex than those resulting from everyday incidents. These injuries often require comprehensive rehabilitation that addresses both the physical and psychological impacts of the trauma.

The consultation incorrectly compares car accident treatment to the treatment of significantly simpler injuries such as seen with the WSIB. This is a red herring that fails to recognize the complexity and interconnectedness of treating multiple injuries at the same time, where treating one area of injury hurts another and vice versa. No healthcare professional would have ever written the statement in the consultation, and it really misses the mark and is essentially untrue.

Car accident victims require more intensive and prolonged care to achieve full recovery as outlined in the goals of the accident benefits framework, (previously included) which is not adequately supported by the current PSG and MIG rates.

Finally, the goal of WSIB treatment, which is simply to achieve a modified return to work regardless of full injury recovery, is not the same as the goals within the Motor Vehicle Accident (MVA) framework, where the aim is a complete return to pre-accident level of function. Comparing these two frameworks is inappropriate, as the differences in rehabilitation goals ultimately determine the cost of care.

In WSIB cases, the treatment objective is met when a worker is able to return to work, even if it's on modified duties or with ongoing functional limitations. This often results in shorter treatment periods and less intensive rehabilitation, which keeps costs lower. However, the Statutory Accident Benefits Schedule (SABS) demands a higher standard of recovery. The goal in the MVA framework is to restore a patient to their pre-accident level of ability and function, which often requires more extensive and longer-term treatment.

The higher cost associated with MVA care is directly linked to this **more comprehensive rehabilitation goal.** Achieving a full recovery demands a greater commitment of time, resources, and healthcare expertise to ensure patients can return to their normal daily activities without limitations. Therefore, the complexity and intensity of care required in the MVA framework are inherently more costly than the WSIB approach, where the goal is simply a modified return to work.

Remuneration Discrepancy Between Other Healthcare Professionals and Tradespeople

It is unsettling that insurance adjusters often pay more for tradespeople, such as plumbers, than for healthcare providers responsible for helping patients recover from life-changing injuries. For example, companies employing plumbers charge $195 for an hour of work, while physiotherapy clinics receive less than half that amount for an hour of treatment.

The low rates paid to healthcare providers devalue their critical work and cognitive labor, undermining their ability to deliver high-quality care. This discrepancy affects providers and harms patients who receive insufficient care and face poorer outcomes.

The short-sighted approach we take towards rehabilitation of undercompensating healthcare providers increases long-term costs for society. Patients who do not recover fully are more likely to rely on public healthcare and welfare systems, increasing the financial burden on taxpayers.

Psychologists in Ontario typically charge $300 per hour for their services, which often include counselling and mental health support. This fee is for a 50-minute session, reflecting the value placed on psychologists specialized, focused work.

People who don’t recover from physical injuries develop chronic pain; chronic pain is three times more expensive to the economy than all cancers combined.

The recommended rate for rehabilitation services, including physiotherapy, occupational therapy, and speech therapy, should be more in line with a psychologist in private practice. Any new rate should take into consideration the comprehensive nature of the intended goals of car accident treatment, the often-multifactorial nature of the injuries, the significant educational requirements and cognitive labor involved in treatment services, and the significant charting and fixed cost and space requirements in an increasingly litigious system. Clinic owners today are waiting for the result of these consultation to ascertain their next steps.

Systemic Unconscious Bias Against Female-Dominated Professions needs to be addressed

Rates need to increase due to the systematic undervaluation of female-dominated professions such as physiotherapy, occupational therapy, and speech therapy. FSRA has perpetuated the unconscious bias in the Professional Services Guidelines (PSG) and attendant care framework, where these professions, predominantly staffed by women, are compensated at significantly lower rates compared to male-dominated fields

(chiropractic). This reflects a broader societal trend where work performed by women is undervalued and lacks the financial recognition it deserves. To correct this disparity and ensure fair compensation, rates for these essential healthcare services must be adjusted to reflect their true importance and value in the healthcare system.

It's unreasonable that a registered physiotherapist is paid less for providing physiotherapy services than a chiropractor, despite both professions offering essential, hands-on care. Physiotherapy, a profession predominantly made up of women, is undervalued in comparison to chiropractic, which has a primarily male workforce. This disparity raises important questions about gender equity, and one can't help but wonder when this imbalance will finally be addressed.

Importance of Charting in Rehabilitation:

Charting plays a vital role in rehabilitation and should not be viewed as an administrative expense. However, insurers exclude the legal requirement for healthcare professionals to document patient care, claiming that the Professional Services Guidelines (PSG) should account for all administrative costs.

Failing to recognize charting as part of treatment costs undermines the value of healthcare professionals' work. Our charts are legal documents, and like the mandatory forms we fill out, they deserve fair compensation. Unfortunately, healthcare professionals lack effective means to dispute these issues. Charting is essential for documenting care plans, ensuring legal compliance, and coordinating patient treatment with other healthcare providers.

Just as lawyers and independent adjusters are compensated for drafting legal documents, charting in healthcare is a legal obligation that requires time and expertise. It's not optional, and healthcare professionals must be paid for this work—just as FSRA employees and insurance adjusters are compensated for their duties during regular hours. Ignoring this reality diminishes the importance of thorough, professional documentation in patient care.

Goals, KPI, our Outcomes

The goals for reform should be clear and focused on improving outcomes for both patients and healthcare providers.

Firstly, I suggest FSRA improve insurer value for money to consumers by monitoring recovery rates and return-to-work outcomes, shifting the focus from cost containment to patient well-being and return to productivity. This would lead to better outcomes for individuals and society and is consistent with the goal of our insurance products to prevent such losses to society.

Second, insurance practices must be aligned with broader public health goals, ensuring that fees paid to healthcare providers are sufficient to cover the cost of comprehensive care, ultimately reducing long-term costs associated with chronic conditions and disabilities.

Third, it is crucial to address the systemic bias against female-dominated professions in the fee-setting processes. This involves revising fees to accurately reflect the value of services provided by physiotherapists, occupational therapists, and speech therapists, ensuring these professionals are fairly compensated for their essential work.

By implementing these changes, Ontario can create a healthcare system that meets patient needs while supporting the province's broader economic and social well-being. It is time to move beyond short-sighted cost-containment strategies and adopt policies that prioritize full recovery, economic efficiency, and social equity.

We need to take a rehab lens and a healthcare framework and apply it to the rehabilitation benefits we deliver post MVA.

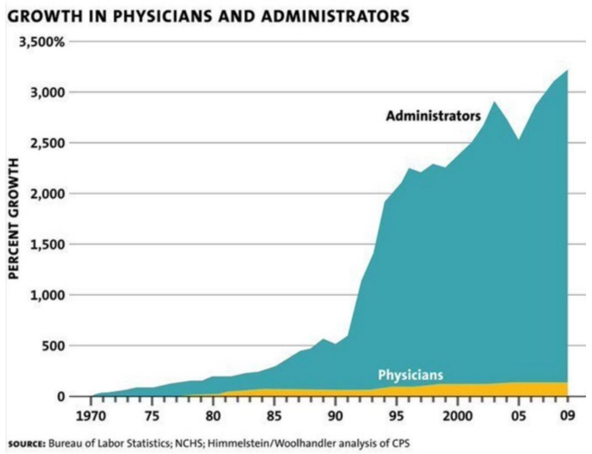
Measure the following post MVA and watch premiums go down and Society per capita GDP go UP:

-***disability durations,***
-***return-to-work rates, reduced reliance on pain management,***
-***rates of chronic conditions***
-***rates of mental health issues****, and*
-***the strain on families and social support systems***.

Anti-Consumer Implications of administrative costs within the Statutory Accident Benefits Healthcare for Professionals and Consumers

In our current SABS system, we have perversely incentivised administrative burdens. It is more rewarding for insurers to create administratively burdensome processes for healthcare professionals and consumers that to create LEAN and efficient processes. This is because these administrative costs can be marked up by insurers and passed along in premiums, turning them into a no-risk profit center for the insurers. Yet, consumers and the professional community bear these higher costs differently and cannot offset these expenses, since their rates are fixed or as in the case of consumers have no choice but to pay for insurance.

Insurance companies of all types benefit financially from this system, profiting from the administrative complexities they create while medical professionals absorb the increased costs. This issue (administrative burden increasing costs) is a noted problem in the American healthcare system and is no different in other mandated insurance products (auto insurance) where consumers must purchase essential products, the number of administrators is increasing healthcare costs despite the human bottleneck of care delivery.



The statement in the Statutory Accident Benefits regulation that "The rates and fees found in the PSG include all administration costs, overhead, and related costs, fees, expenses, charges, and surcharges is problematically unfair and encourages abuses of process by insurers.

This rule **shields insurers from the administrative abuses of process or administrative burdens that they impose on healthcare professionals to the detriment of auto insurance consumers.**

We have created an imbalance of power and with major consequences:

1. Devaluation of Healthcare Professionals' Time: By including all administrative costs in the PSG rates and refusing to allow any additional charges, this proposal devalues the significant time and effort healthcare professionals must spend on administrative tasks.

   When professionals are not compensated for this work, it sends the message that their time is not valued, which can disincentivize their participation in the auto insurance system.

2. Unchecked Behaviour of Insurance Adjusters: This framework emboldens what could be described as 'cowboy' behaviour among insurance adjusters, who already operate with limited oversight in their interactions with consumers and healthcare professionals.

3. Without checks and balances on how adjusters interact with healthcare providers, this imbalance allows insurance companies to drown professionals in unnecessary paperwork and red tape. Adjusters can, and often do, request large volumes of information without compensating healthcare providers for their time. This behaviour, which can border on abusive, leads to a significant strain on the system and creates inefficiencies, ultimately hurting consumers. **We need an insurance adjuster code of conduct.**

A Lack of Accountability and Protection for Consumers

There is currently no meaningful oversight of how insurance adjusters interact with healthcare professionals. The Financial Services Regulatory Authority of Ontario (FSRA) has not conducted any surveys or polls among healthcare providers to determine what types of insurance adjuster behaviour could be considered an abuse of process. Nor has it examined how these behaviours directly impact consumers, particularly in the early phases of accident benefits when injured individuals are most vulnerable.

This lack of oversight has allowed insurance companies to leverage their position of power without consequence, and it leaves healthcare professionals at their mercy. The resulting impact is clear: if healthcare professionals are bogged down by excessive paperwork and

constant demands from adjusters without compensation, they withdraw from treating accident victims under the auto insurance framework altogether. This restricts consumer access to quality care and delays recovery, as patients are left without timely treatment options.

However, this short-term gain in profit due to administrative costs for insurers ultimately comes at a high cost to consumers and the entire system.

- Delayed Care: When healthcare professionals are overwhelmed with administrative tasks without fair compensation, they become less willing or able to engage with accident victims, leading to delayed or inadequate care.

- Increased Costs to Consumers: While the regulation may appear to protect consumers by controlling costs, it ironically creates inefficiencies that raise long-term costs. Consumers end up paying more because the system itself becomes more expensive to manage over time.

FSRA's Missed Opportunity

The Financial Services Regulatory Authority of Ontario has an obligation to protect consumers, but its lack of attention to how insurance adjusters interact with consumers or healthcare professionals leaves a significant gap in consumer protection. FSRA is failing in its responsibility to ensure that consumers are safeguarded from harmful insurer practices. Ontario has created a system where consumers are the ultimate losers.

People in car accidents are tired of the endless hassle and battles; many just give up, deciding it’s not worth the time. Unfortunately, temporarily stopping only becomes more costly later when unresolved issues spiral into serious, sometimes irreversible problems. In the end, consumers are left as the ultimate losers in a system that should be working for them.

Lack or real data does not promote consumer protection; it promotes systemic inefficiency and emboldens abusive practices by insurance adjusters. Without checks and balances, healthcare professionals are devalued, and consumers bear the cost through delayed care and long-term health impacts. For a truly fair system, FSRA must ensure that healthcare professionals are compensated for their time and that insurers are held accountable for their interactions with patients and providers.

How dueling assessments are bankrupting the system with little benefit for consumers

Based on the 2022 data from the Ontario Health Claims Database (HCDB), it is evident that the systemic issues regarding dispute resolution and administrative costs, particularly those related to disputing treatment plans, are a major problem in our healthcare system.

A significant portion of the resources**—43%** 278 million out of 645 million**—** are dedicated to administrative battles, insurance examinations to dispute treatment plans, rather than being used for direct patient care.

So, for every dollar spent on care we spend almost the same amount on disputing care. This money goes to a limited number of closed preferred provider network of insurance examiners who are also often treatment preferred providers. There is no doubt that the insurance examination business is the most lucrative component of accident benefits since out of the 4900 licensed health service providers that provide direct care very few are insurance examiners and between them they consist of 43% of all HCDB costs in 2022 which is about 278 million split between a few companies.

However, what the HCDB data does NOT include is equally important: it does not account for settlement costs, the costs for assessments and disbursements ordered by law firms to rebut insurance examinations, or the fines and penalties that insurance companies incur that drive up costs so the 43% is actually significantly more. This omission masks the true extent and cost of the administrative bloat in the system which is likely more than all direct care costs for patient rehabilitation.

When you deliver care in the auto insurance system, it becomes clear that direct treatment physiotherapy and rehabilitation costs are not the driver of healthcare expenditures. In fact, with fewer accidents year over year and decreasing direct patient rehabilitation costs, it's clear that the real cost drivers are the administrative processes and medical examinations.

Denials often come early on in a claim and direct treatment at a clinic will stop shortly thereafter. Then the years long processes, often involving duelling assessments, and LAT conferences, provide little value to consumers while consuming a large portion of the resources allocated to healthcare. The costs of medical assessments and the entire antagonistic industry surrounding them have become significant contributors to the overall expense, overshadowing the actual costs of delivering rehabilitation.

Relying on closed Preferred Provider Networks (PPNs) for insurance examinations make things worse and recovery more unlikely. Preferred Provider Networks never offer true value for consumers or improve patient outcomes. The outcome of an assessment can often be predicted based on who ordered it (insurer or lawyer) and the company that performed it.

Participants in these networks are chosen by insurers not for their impartiality, but because they align with the internal biases of the companies that employ them. These companies employ professionals who hold certain beliefs regarding recovery rates, ensuring that the assessments produced favour cost-cutting measures rather than actual patient care.

It's reasonable for a company to want to get value for expenses, and the phrase ***"whoever pays the piper calls the tune"*** accurately describes this situation of dueling assessments.

This bias isn't limited to one side—both insurers and law firms engage in similar practices. They often order assessments from providers who are likely to deliver conclusions that align with their interests, essentially knowing the outcome before the examination even begins. This practice of "duelling assessments" wastes substantial resources, as the assessments often cancel each other out, offering no value to the system. Instead of helping resolve cases fairly, these assessments only prolong administrative battles, delay care, and drive-up costs.

A key part of the problem is that these closed preferred provider assessment centres are fully dependent on the business they receive from insurers or lawyers. To keep the work flowing, they feel pressure to produce reports that meet the expectations of the paying client, often at the expense of what the patient truly needs. This creates a cycle where reports are more about pleasing the client than delivering objective, patient-centred evaluations.

Since these administrative and assessment costs are shouldering a significant portion of the total rehabilitation expenditures (more than 43%). We could cut almost half of all healthcare expenditures immediately if someone has a better idea that was objective, provided better and faster results. – **keep reading.**

Consumers are not getting the value they deserve from a system that is supposed to focus on their recovery. Instead, almost half of the expenditure is being funneled into a process that prioritizes administrative disputes over patient care, contributing little to actual health outcomes. If we are to restore value and efficiency in our healthcare system, if we want to lower auto insurance costs we need to find a cheaper dispute resolution mechanism. The focus needs to shift away from PPN assessments and towards reliance on the existing regulated healthcare framework.

Auto insurance regulators, through HSP licensing, are inefficiently and expensively attempting to replicate systems that already exist within the self-regulated professional college model. In regulated healthcare frameworks it's referred to as **"obtaining a second opinion".**

When a clinic is owned and operated by a regulated healthcare professional, the existing regulatory framework already protects the public. The current insurance examination system adds layers of costly redundancy, to provide an opinion that is not very robust,

while at the same time has very little consumer protection, patient oversight, and is ineffective. It neither reduces administrative burdens nor improves patient care, as there is no duty of care within the insurance examination process.

The rising costs in rehabilitation are not due to direct therapist-to-patient treatment, but rather are driven by inefficiencies and systemic problems in the broader framework. These include excessive administrative burdens, redundant provider licensing requirements, conflicting assessment processes during disputes, and prolonged resolution times through the Licence Appeal Tribunal (LAT). Many of these disputes could be resolved more efficiently and objectively by using a second-opinion system within the existing self-regulated healthcare framework, instead of relying on costly and time-consuming insurance exams.

In essence, the true cost drivers of auto premiums lie in poor system design of the components within the system and inefficiencies, not in the direct care provided by therapists to patients.

The Hidden Costs of Delayed Care: Why Ontario's Auto Insurance Dispute System Needs Urgent Reform

The hidden cost of Ontario's auto insurance dispute system? Delayed, unresolved care. Today, the LAT (License Appeal Tribunal) process can stretch on for years, leaving injured people in limbo. With a five-year limit to receive treatment unless injuries are deemed catastrophic, here's what happens: if a person's claim is denied, they might struggle for over a year before finding a lawyer willing to take it on. By the time a LAT claim is filed—often two years post-injury—it could take another two years just to get a decision. Now, they're four years in, facing chronic injuries with only months left to receive treatment – so they get a financial settlement to ease their reliance on ODSP. The result? Insurers save big, but society pays the price. Now you know.

The delays in accessing dispute resolution mechanisms through the License Appeal Tribunal (LAT) system have serious consequences for injured individuals seeking accident benefits and treatment plan approvals. The imposition of complicated tribunal processes not only creates excessive administrative burdens but also prolongs the time it takes to resolve whether someone should receive the care they urgently need.

The truth is, the existing regulatory healthcare framework, which allows for second or third opinions within the healthcare system by the same type of professionals, offers faster, cheaper, and significantly more reliable outcomes for addressing accident benefit disputes. By relying on physiotherapists and chiropractors the healthcare professionals who are already working in the system and regulated to make these decisions, disputes can be resolved more quickly, getting patients the care they need and lowering costs for all parties involved, including the government.

The increased costs to the government, insurance settlements, and society are enormous when individuals don't receive a timely resolution. When timely access to care is delayed, injured individuals get worse, not better. The idea that withholding care will lead to recovery is a myth.

People injured in car accidents are not like someone who sustained a repetitive strain injury at work, or who woke up with a stiff neck; their injuries often require immediate and sustained treatment. These are not simple cases, and most patients are middle aged people who were in traffic on their way to work, hardworking individuals with jobs and families to support. They can't afford to wait years for a decision from the LAT on whether they can access care.

These people aren't wealthy. They're often working-class individuals—the backbone of society—who need to get back to work to feed their families. Our society is often overweight and the last time they worked out was the day before they were married. They are not fit. They need access to care quickly, and the current system of imposing LAT

processes for treatment plan disputes creates a bureaucratic bottleneck. When it takes two years or more for a decision, insurance companies benefit from the long timelines, society loses. The recently reduced five-year deadline for health benefits allows insurers to drag cases out, meaning someone can file for LAT at the two-year mark, only to receive a decision 2.5 years later. By that time, there is barely enough time left within the five-year window for the patient to even restart treatment, let alone recover. We have now created a new chronic pain citizen who is dependent on welfare and will no longer appreciate the value of a job. We will create angry people upset at what they lost and demand more because they feel wronged.

Today, patients are forced to settle for payouts without ever receiving the treatment they need, which drives up costs across the board. Instead of focusing on care, the system becomes about settling cases—and that doesn't just hurt patients, it hurts taxpayers, insurance consumers, and society as a whole.

There are fundamental unfairnesses being perpetrated on auto insurance consumers who are unable to access timely dispute resolution mechanisms. Not only does this increase costs to the system, but it also offloads costs onto other sectors, such as public healthcare, and social services. The healthcare costs for those who didn't receive timely care often fall largely on the public system, exacerbating the burden on hospitals and increased use of pain clinics which in the last two decade of auto insurance reforms the public healthcare cost of pain clinics has jumped exponentially and anyone who has been in a waiting room at a pain clinic know the patient population is generally twofold old unresolved MVA patients and old unresolved WSIB patients.

The current system is built to delay, and delay hurts everyone even the insurance companies (but they can pass the costs along). A more efficient and fairer model would return dispute resolution to the healthcare framework itself, allowing for timely second or third opinions from regulated healthcare professionals. This would not only reduce delays and administrative costs but also ensure that people receive the treatment they need to recover, which is ultimately cheaper than settling disputes years down the line.

Ensuring Fairness with Randomized Second and Third Opinions

The process for resolving disputes over treatment plans needs to be redesigned to be fair, transparent, and difficult to manipulate. Financial Services should stop trying to reinvent the wheel and use what works well in other frameworks today. We already have a second opinion system, and it can be used without a systemic bias to provide valid second and third opinions that are not subject to external influence and this would significantly reduce costs and disputes since the party ordering the dispute is not as certain of the result.

When FairCare is a priority above all else, then society wins as do auto insurance consumers.

Here's how it works: (basics)

1. **Initial Treatment Plan**: The patient's healthcare provider creates a treatment plan. If the insurance adjuster questions or disagrees with it, they can request a review for a second opinion.
2. **Second Opinion**: The treatment plan is sent for review to a randomly selected healthcare clinic. This random selection is key—neither the patient nor the adjuster nor the lawyer has any say in choosing the clinic, preventing manipulation. The list of clinics includes those with licensed professionals, such as physiotherapists or chiropractors, who are auto insurance providers for rehabilitation services. Importantly, the assessment must be conducted by a professional from the same discipline as the one who created the original treatment plan—if it's a physiotherapy plan, a physiotherapist reviews it. This ensures the assessment is made by someone with the right expertise.
3. **Third Opinion (If Needed)**: If the second opinion sides with the insurance adjuster and there is still disagreement, the patient is entitled to a third opinion. This third assessment, also done by a randomly selected professional of the same field, serves as the tiebreaker.
4. **Final Decision**: The outcome is based on the agreement between two out of the three assessments. This "two out of three" rule ensures that the majority opinion of experts, not just one side, drives the final decision.

This approach is simple, transparent, and ensures fairness by removing bias and potential manipulation from the process. The random selection of clinics and the requirement that assessments be conducted by professionals of the same discipline ensures the integrity of the system. This aligns with the professional associations, which advocated for same-profession reviews—a practice that was common before changes were made over a decade ago. This system of focused assessments would be cheaper and be able to provide insights currently not provided.

Treatment Plans Submitted for review would be reviewed for the following:

1. Does the Patient have ongoing injuries due to the motor vehicle accident
2. Is treatment reasonable yes-no
3. If not reasonable would the patient benefit from a maintenance program to maintain their ability to perform ADL's or Work activities.

Implementing this streamlined dispute resolution process is both efficient and consistent with LEAN principles because it eliminates unnecessary steps, reduces waste, and focuses on adding value to patient care. By utilizing the existing regulatory healthcare framework and relying on regulated healthcare professionals for unbiased second and third opinions, we avoid duplicating systems and unnecessary bureaucracy—in essence, not reinventing the wheel. This approach leverages established structures and expertise, leading to significant cost savings and a more efficient process overall. It ensures fairness, enhances transparency, and prioritizes patient outcomes while minimizing administrative burdens and expenses, ultimately creating a more sustainable and effective system for all stakeholders.

"Simplicity is the ultimate sophistication."
— Leonardo da Vinci

Why it Works:

This proposal for a randomized second and third opinion system represents a substantial shift in how disputes between clinics, insurance adjusters, and lawyers are resolved, creating a self-regulating ecosystem that encourages fairness and professional accountability. Here's an analysis of how this system changes the dynamics and promotes better behaviour among the involved parties:

Dynamics Between Clinic and Adjuster:

1. Neutralizing Power Imbalance: In the current system, insurance adjusters may hold disproportionate power, as they can often choose the clinic or professional to conduct assessments, potentially creating biased outcomes. This proposal removes this power by introducing randomized clinic selection. This randomness limits the ability of either side (adjuster or clinic) to manipulate the assessment outcome, thereby creating a more level playing field.

2. Reducing Unnecessary Disputes: Since adjusters can no longer choose assessors, they are less likely to dispute a treatment plan frivolously, knowing that they won't have control over who provides the second or third opinion. This could significantly reduce the number of disputes, saving time and costs while improving relationships between adjusters and clinics.

3. Transparency and Predictability: The randomness and professional discipline matching ensure that both the clinic and adjuster can trust the objectivity of the process. This transparency reduces the need for repeated back-and-forth arguments and helps focus on the merits of the case, rather than who can manipulate the system better.

Dynamics Between Clinic and Lawyer:

1. Less Legal Involvement: Lawyers currently play a significant role in disputes, especially when disagreements drag on and lead to litigation. By implementing a transparent second and third opinion system, the need for lawyers to mediate disagreements could be reduced, as disputes can be resolved faster and more efficiently. This frees clinics to focus on patient care rather than becoming embroiled in legal battles.

2. Clarified Responsibilities: In this system, clinics maintain their professional autonomy and focus on delivering proper care, while the legal process becomes secondary. Lawyers may need to adjust their role to focus more on supporting the patient's rights and advocating for clarity in other areas rather than driving disagreements over treatment plans.

3. Promoting Ethical Behaviour: Since decisions would be made by neutral, randomly selected healthcare professionals, the temptation for any party to "game the system" by hiring a favourable lawyer or clinic would decrease. This fosters an environment where professional ethics and medical standards guide decision-making, rather than strategic legal manoeuvring.

Promoting Proper Behaviour and a Self-Regulating Ecosystem:

1. Accountability and Integrity: The system naturally promotes accountability among all players—clinics, adjusters, and lawyers—by limiting opportunities for bias and manipulation. Each side knows they can't influence the outcome through external means, so the focus shifts to professional conduct and fair evaluation of treatment plans. The randomization ensures that no one party benefits unfairly from disputes.

2. Professional Peer Reviews: The requirement for second and third opinions to come from professionals in the same discipline reinforces professional integrity. When one physiotherapist reviews another's treatment plan, there's an inherent understanding of the clinical nuances, which results in more accurate and meaningful assessments. This peer-based review process strengthens the overall quality of care.

3. Incentive for Proper Initial Treatment Plans: Clinics are incentivized to create high-quality, well-justified treatment plans from the start, knowing that their plans will be reviewed by a peer. This also means that adjusters must be reasonable in their challenges, as baseless disputes could easily be overturned in the second or third opinion.

Impact on System Design and Efficiency:

1. Efficiency and Cost Savings: The proposed system aligns with LEAN principles, focusing on eliminating unnecessary steps and waste. The current system, with its many layers of assessment, litigation, and legal interventions, is inefficient and costly. By simplifying the process and removing unnecessary bureaucracy, the second and third opinion system streamlines dispute resolution, resulting in quicker decisions and reduced administrative costs.

2. Improved Patient Outcomes: By reducing delays caused by drawn-out disputes, patients receive care more promptly, leading to better outcomes. The system also ensures that treatment plans are reviewed by experts who understand the patient's needs, rather than assessors driven by external factors like insurer demands.

3. System Sustainability: The cost savings, transparency, and reduction in legal interventions contribute to a more sustainable system. Clinics and insurers alike can allocate resources more effectively, and patients benefit from a process that prioritizes fairness and timeliness. This creates a virtuous cycle, where better behaviour is rewarded, and the overall system improves.

This randomized second and third opinion system fundamentally shifts the dynamics between clinics, adjusters, and lawyers, fostering a self-regulating ecosystem where professional accountability, fairness, and patient care are prioritized. It reduces opportunities for bias, streamlines dispute resolution, and enhances the ethical behaviour of all involved. By leveraging existing frameworks and focusing on expert peer reviews, the system not only improves efficiency but also ensures better outcomes for patients, insurers, and healthcare professionals alike.

It's about FairCare.

An Additional Systemic Issue That Increases Costs to Consumers and Disputes:

The SABS currently limit the scope of practice of physiotherapist this is a problem that must be the addressed since it increases inefficiencies. *Limiting the scope of practice means restricting what tasks a physiotherapist is legally allowed to perform; this further reduces system efficiency.*

Physiotherapists have the authority to make a diagnosis, communicate or convey a diagnosis of another professional. Yet often insurance adjusters refuse to accept our communication and request a note from a medical doctor, often resulting in an ER visit and significant treatment delays. This creates inefficiencies in the, requiring multiple healthcare providers to perform tasks that could easily be managed by a physiotherapist.

Allowing physiotherapists to communicate diagnoses made by other professionals would improve care and also reduce the number of disputes over treatment this is done within other frameworks such as the WSIB.

Many insurance adjusters are unaware of the full scope of physiotherapy education and practice, and with a typical adjuster turnover of 3-5 years, healthcare professionals are constantly dealing with new adjusters who are relearning the system—adding to inefficiency.

It would also be highly beneficial for the FSRA to provide a standardized FAQ for adjusters to address common dispute issues. However, the FSRA has not prioritized efficiency in this area, though it absolutely should.

The WSIB: A **Cautionary** Tale

The current narrative about how WSIB turned things around is not exactly true. Many believe the narrative that programs of care saved the day, this is incorrect.

When rehabilitation costs are improperly suppressed, they boomerang back onto the system that holds the ultimate legal liability, ultimately costing society and the original system more. Historical evidence from the Workplace Safety and Insurance Board (WSIB) in Ontario and the implications of these practices for auto insurance today highlight the importance of these consultations

In the early 1990 and 2000s, WSIB in Ontario often denied treatment to injured workers, compelling them to resort to the government-funded OHIP system, this system was then very accessible and unrestricted. These patients received years of analgesic care under "G code" interventions within physician offices. When these patients finally pursued their disability rights in court or within a legal framework, WSIB was left defenseless against their claims, leading to a surge in liability costs. This situation is analogous to the current scenario where accident victims are denied care and begin attending publicly funded chronic pain clinics for injections and monitoring, incurring significant costs to the publicly funded system and auto insurers will end up paying a settlement in the end. To prevent this eventual outcome a system needs to be self-regulating in an unimpeachable manner, or it will find itself with significant liabilities.

The Boomerang Effect of Suppressed Rehabilitation Costs

The suppression of rehabilitation costs has a boomerang effect, causing legal consequences and financial burdens. The 2009 Ontario Auditor General's report highlights how the unfunded liabilities in the WSIB system were exacerbated by factors such as economic downturn, legislative changes, increasing benefit costs, rising health care costs, workplace behaviour, and investment performance.

The WSIB's increasing liabilities were:

- A consequence of under-valuing and under-funding rehabilitation treatments.
- Forcing patients into the public health system.
- Later facing uncontested disability claims.

Rehabilitation Costs and Auto Insurance: Current Scenario

Similar to the WSIB situation, auto insurers, too, face the repercussions of suppressing rehabilitation costs. When treatment is denied, injured victims resort to obtaining care on a contingency basis or enter the publicly funded network of chronic pain treatment centers,

eventually leading to an increase in settlement claims due to the prevalence of chronic pain.

This shifting of burden onto the publicly funded system results in a significant drain of resources. The public system, designed to cater to all citizens, ends up shouldering the responsibility of caring for accident victims whose treatment costs should have been covered by private insurers.

Response to PSG Proposed Options

Response to Option D – PSG: Status Quo – Maintain Existing Hourly Rates

Stating that "FSCO did not have a legal obligation to review or increase the PSG rates and fees on a regular basis, nor does FSRA," is true. Yet it's not required given the emotional effect it should have been known to have.

The reliance on the absence of a legal mandate to justify preventing a harmful outcome is not an appropriate sentiment. All Healthcare professionals are grateful to the Ministry of Finance for these consultations since we can see that in practice the FSRA is not willing to engage in conversations that can improve the system unless it has a legal obligation to do so. – this is wrong.

Healthcare professional bound by ethical frameworks often talk about fairness, FSRA in stating this is choosing to highlight being legally right rather than doing the right thing (I cannot respect this type of bureaucratic nonsense.) This may be the language of bureaucracy, or the language of its' mandate regardless this language is not prudent or wise.

After 25 years of fee stagnation, Option D makes it difficult for healthcare professionals to feel valued or heard and more professionals will leave Ontario and blame the government if 25% increase is all that is received. Option D is political suicide for any government.

FSRA presenting an option that keeps rates unchanged after such a long period sends the wrong message about government. It gives the impression that the contributions and challenges faced by healthcare providers "healthcare heroes" are not being fully acknowledged and that a consumer's recovery after a car accident is of no value.

This is due to a focus on the wrong short term performance indicator, auto insurance rates.

Stagnant fees have made it increasingly difficult for healthcare professionals to sustain their practices, particularly in the face of rising operational costs. Many have been working tirelessly to deliver the best care possible, despite the economic pressures. Proposing no change to these rates, at a time when inflation and other factors have made it harder to provide care, will lead to further discouragement within the profession and a closure of clinics and an exodus of healthcare workers, it will reduce the value of the benefit injured victims receive.

In this context, Option D feels like it overlooks the reality. A fair adjustment to these rates is not just about compensation—it's about creating a sustainable system that allows healthcare providers to continue serving the public effectively. It's important that the solutions we propose reflect the long-term sustainability of the sector, and unfortunately, Option D does not seem to align with that goal. It's about paying for care today to avoid litigation, settlements and administration claim costs altogether.

Insurance companies must innovate to remain sustainable and propping them up by under-compensating healthcare professionals reduces their incentive to find more efficient and innovative ways to manage costs. This imbalance distorts the market, discourages progress, and creates inefficiencies.

Favouring one sector—insurers—at the expense of another—healthcare providers—disrupts the market, leading to inefficiencies and sectors that rely more on government support than on innovation and competitive delivery. For a truly sustainable system, we must encourage all sectors to innovate and grow, rather than protect one at the expense of others. The long-term success of the insurance market depends on a balanced, fair approach that supports innovation and sustainability across the board.

Response to Option C: Do Not Prescribe Rates

This option overlooks the power imbalance that exists between consumers, healthcare service providers (HSPs) and insurers. While the idea of allowing "reasonable" or "market rate" fees to be negotiated between providers and insurers may seem like it offers more autonomy, it ignores the practical realities of how negotiations work when there is such a disparity in size, resources, and influence between the two parties.

Option C is fundamentally unfair: which would be another political hot potato and result in voter anger.

Insurers hold a significant advantage in these negotiations due to their size, financial strength, and ability to wait and dictate terms. Healthcare providers, many of whom are small clinics or independent practitioners, are not in a position to negotiate on equal footing. For these providers, accepting whatever terms the insurer proposes may be their only option to ensure their patients get the care they need. This dynamic leads to unbalanced negotiations, where insurers can impose lower rates under the guise of "market rate" or "reasonable," leaving providers with little room to argue.

No agency in the world has allowed this. In the U.S. the rates are pegged to Medicare and Medicare ensures its numbers do not hinder free market principles to ensure a sustainable and innovative marketplace.

Furthermore, patients are the ones who suffer most under this model. When a consumer and healthcare provider's ability to negotiate fair compensation is limited by the overwhelming power of insurers, they may be forced to cut corners, offer less comprehensive care, or even leave the auto insurance sector altogether. This creates reduced access to care for accident victims, which contradicts the purpose of the auto insurance system—to ensure that those injured in accidents get the treatment they need. Injured patients can't afford to wait through drawn-out negotiations or, worse, lose access to vital healthcare services because providers are driven away by unfair compensation models.

It's also important to note that market rates vary significantly depending on a variety of factors, including geographic location and the complexity of care provided. Without a consistent, regulated framework in place, there is no guarantee that rates will be set fairly across the board. Insurers could push for lower rates in areas where healthcare providers have fewer alternatives, forcing them to either accept inadequate compensation or stop treating auto accident victims altogether. This would create regional disparities and further limit access to necessary care in underserved areas.

Regulation exists to protect consumers and ensure fairness in markets where there is a significant imbalance in power. By removing prescribed rates, FSRA would be allowing

insurers to dictate terms with little oversight, which could lead to a race to the bottom for healthcare compensation. This would not foster a competitive or fair market, but rather encourage insurers to minimize costs at the expense of healthcare providers and, ultimately, patient care.

The FSRA's role as a regulator should be to ensure balance and fairness between all parties, not to shift more power into the hands of one sector. Removing the framework that ensures consistent, fair compensation for healthcare providers would undermine the very purpose of the regulatory body: to protect consumers, support fairness, and maintain a sustainable system that serves the public's interest.

In conclusion, Option C is not a fair solution. It risks creating a system where those with more power and resources dictate the terms, leaving healthcare providers at a disadvantage and ultimately reducing the quality and accessibility of care for patients. The FSRA must continue to play an active role in setting fair rates to ensure that the system remains equitable and serves the needs of everyone involved.

FSRA doing this will be placing too great a risk on consumers.

Response to Option B – PSG: Move to Flat Rate Fees

Option B raises significant questions about how the flat rate approach would even be implemented, given that flat fees are not clearly defined. What exactly does FSRA mean by "flat fees"? Are we talking about a flat session fee like we had in 1996, or is this a block fee model, similar to the one used in the MIG? Without proper definition, this proposal leaves healthcare professionals and patients in the dark.

Option B also makes one wonder if the Regulator is actually trying to make the government look bad by imposing ideas that have no framework behind them that would justify flat rates.

The reality is that any flat fee system must be tied to a reasonable and transparent rate, otherwise, it risks leaving healthcare providers under-compensated and patients under-treated. Flat fees sound simple on the surface, but healthcare is not a simple service. The complexity and variability in patient needs mean that trying to squeeze treatment into a one-size-fits-all flat fee is not only unrealistic but could result in lower-quality care and longer recovery times for patients.

This brings us to a fundamental issue: there is work that needs to be done here. Financial services regulators have not reviewed rates for over a decade in the case of PSG, and for 15 years in the case of MIG. It may not have been illegal for them to neglect this responsibility, but it certainly wasn't in the best interest of consumers, patients or the auto insurance treatment framework. It's time to roll up our sleeves and do the work to fix this.

Any flat fee will inevitably need to be pegged to an underlying hourly rate to ensure fairness for both healthcare professionals and patients. A flat rate without this context is arbitrary, and arbitrarily set fees will only lead to underpayment for healthcare providers, resulting in a system where consumers and patients do not get the time and care they require for recovery and return to work.

Setting a fair, transparent hourly rate is the first step, and flat fees—if they are to be implemented at all—must be directly linked to this reasonable rate. Anything less would be a disservice to patients and healthcare providers alike.

Consideration that could offset a portion of the rate increase is the removal of the redundant licensing system for clinics already governed by regulated healthcare professionals. If this were implemented.

Response to Option A – PSG: Index the Maximum Hourly Rates

The only option is to increase rates. Yet we need to address their years of inaction and own up to it or risk the government looking indecisive. The mandate of a previous government should be noted as a foundational misstep against healthcare professional the tens of thousands of businesses that are health service providers deserve a proper rate increase as do consumers who have been paying for benefits that have failed to get them better due to rates being less than anywhere else in Canada. The best path forward is the fairest path forward for auto insurance treatment sustainability.

In 1996, the market rate for healthcare providers in the auto insurance sector was up to $120 per session. Fast forward almost three decades, and despite rising costs, inflation, and the increasing complexity of healthcare, the rates have not even kept pace with the cost of living. If indexed appropriately since 1996, especially considering the higher rate of healthcare inflation, which exceeds the Consumer Price Index (CPI), the rate today would be far higher than the current $99.75 per hour.

Healthcare inflation has consistently outpaced general CPI because of the rising costs of labour, technology, and regulatory compliance within the sector. From 1996 to today, healthcare providers have absorbed increased costs for everything from equipment to administrative support. Given that inflation in healthcare tends to be driven by forces like technological advancements, staffing shortages, and increased regulatory demands, simply indexing to CPI is insufficient. A realistic adjustment would reflect the true costs of delivering care today and would be higher than the CPI alone.

FSRA's reluctance to adjust fees for another 15 years is not out of the question given their lack of legal mandate to do so—historically, the PSG rates have not been reviewed or updated in a timely manner, with the Minor Injury Guideline (MIG) rates not being updated for 15 years. This tendency to delay reviews results in an ever-widening gap between the actual cost of delivering care and what providers are reimbursed, effectively squeezing healthcare professionals out of the system.

It's not just the auto insurance sector that's suffering—this overly regulated system has led to healthcare providers leaving Ontario altogether. Redundant licensing and compliance costs have added unnecessary expenses to treating motor vehicle accident (MVA) patients, further burdening providers. The added cost of managing duplicate regulatory requirements does nothing to improve patient outcomes but significantly increases the overhead for clinics, making it even more difficult to operate at current PSG rates. If these unnecessary layers of bureaucracy were removed, it might help alleviate some costs, but that alone won't solve the problem. The root issue remains: the hourly rate is woefully outdated and insufficient.

In addition to these challenges, charting time, which is an integral part of patient care, is unpaid. The reality is that healthcare providers spend a significant amount of time after hours documenting patient care charting is a legal and ethical obligation. Proper documentation ensures continuity of care and legal compliance, yet this vital work is not acknowledged in reimbursement rates. This, along with the administrative burden, compounds the challenges that providers face, stretching them thin and forcing them to take on unpaid work just to stay compliant.

Given these pressures and considerations, the rate needs to be set at $400 for 50 minutes of care to reflect the real cost of delivering care in today's market. This figure accounts for the historical underpayment, the higher rate of healthcare inflation, the burden of increased administrative and regulatory requirements, the potential for the FSRA to not review rates for another 15 years and the undervalued time spent on charting and care coordination. Anything less will continue to drive providers out of the system and undermine the quality of care that patients receive. Real inflation since 2020 is approximately 20-25%, so an increase in this amount while healthcare operating costs have surged far beyond this since 2020 is insufficient.

Addressing the Considerations of the Consultation:

- **"Aligns with past approaches which increased hourly rates based on CPI":** CPI is insufficient in addressing the unique inflationary pressures of the healthcare industry. Healthcare inflation far exceeds CPI, and aligning with past approaches would perpetuate the problem of undercompensating providers for their services.

- **"Consumers may receive less treatment/care due to increased hourly rates**": This argument assumes that healthcare professionals will charge more for less care, which disregards the fact that higher compensation leads to better care, not less. With appropriate rates, providers can allocate adequate time and resources to each patient, leading to better outcomes and potentially shorter recovery times, which will reduce long-term costs.

- **"Auto premiums may increase":** While concerns about rising premiums are valid, it is worth noting that insurance companies saw profits of 17% during the pandemic. The auto insurance industry has room to absorb rate increases for healthcare providers without significantly impacting premiums, especially if the end result is more efficient, effective care that reduces long-term costs by preventing chronic issues. As stated before short term focus on auto premium increases has not yielded proper systemic changes that have lowered operating costs for the system. Let's not forget direct patient costs only make up slightly more than half of the HCAI costs. A significant portion of costs comes in the form of dispute resolution costs that would remain capped and should be removed altogether when we focus on improving outcomes.

- **"Insurers may object to a large one-time rate increase":** Insurers have benefited from a system where healthcare providers are underpaid. A large one-time increase is necessary to correct decades of under compensation. Staggered increases would only serve to prolong the inadequacies of the current system, continuing to force healthcare professionals out of the sector.

- "Aligns with outcome of consumers receiving the care needed while HSPs are compensated appropriately": This is precisely the point. Appropriate compensation is the cornerstone of quality care. Without fair rates, healthcare providers cannot sustain their practices, and patients will suffer as access to care diminishes.

Conclusion:

The current rates are unfair for healthcare providers, and a significant adjustment is needed to reflect the realities of delivering care in 2025. After decades of stagnation, a rate of $400 for 50 minutes of care is a fair and necessary correction. This figure accounts for inflation, regulatory burdens, and the real cost of patient care, including charting and other essential tasks. This is not a minimum rate it is a rate to deal with patients with multiple areas of injuries and accounts for systemic unfairness that unless otherwise corrected will reoccur.

The FSRA has an opportunity—and an obligation to consumers—to correct this historical wrong and ensure that both consumers, patients and healthcare professionals receive value for money.

Potential ways to offset a portion of the proposed rate increase is by removing the redundant licensing system for clinics that are already governed by regulated healthcare professionals and removing a large portion of the dueling assessment system.

Building a sustainable system is essential. This consultation is an opportunity to undo the damage that has accumulated over the years. This is an opportunity to make decisions in consultations with all stakeholders and not in a silo; to look at how the auto insurance framework impacts public healthcare when decisions are not considerate of their greater impact.

I anticipate that Option A will most likely be the chosen path, so I would like to address a sensitive concern based on historical institutional knowledge.

Addressing Market Entry Concerns for a Sustainable Future

I would like to address a sensitive concern informed by historical institutional knowledge: the issue of market entry from external forces or unregulated entities. Specifically, we have in the past observed challenges arising from entrants outside the regulated framework of healthcare businesses.

To ensure the integrity of the auto insurance rehabilitation market, my proposed solution is straightforward. By implementing limited, short-term barriers to entry for businesses seeking Health Service Provider (HSP) licensing who are not regulated healthcare professionals, we can effectively exclude the small percentage of entrants who cause a disproportionate number of problems as these changes are enacted.

Additionally, if the Financial Services Regulatory Authority (FSRA) concentrates its licensing approach on clinics not controlled by regulated healthcare professionals, it can provide better oversight of this potentially problematic sector that is not directly governed by healthcare colleges.

Removing licensing requirements for clinics owned by regulated healthcare professionals—since these professionals are already overseen by their respective health colleges—would free up FSRA staff resources to focus on other pressing issues that may arise from changes resulting from this consultation.

Moreover, instituting a two-year moratorium on new entrants for non-regulated clinics and health service providers into the FSRA licensing and Health Claims for Auto Insurance (HCAI) systems—except for those regulated by healthcare colleges—would provide the system with much-needed short-term supply stability and resources to manage the implementation logistics of this consultation.

Introducing a requirement that any clinician seeking to be an HCAI Authorizing Officer must have at least five years of professional rehabilitation experience would further ensure higher standards across the industry. These measures would afford the system the necessary time to reach a new market equilibrium before considering any further expansion.

It's evident that significant increases in the Professional Services Guidelines (PSG) and Minor Injury Guideline (MIG) rates are essential to prevent a collapse of the market that serves auto insurance consumers. Many clinic owners, myself included, are awaiting these critical decisions to determine how we will navigate the future. (basically, we are waiting to see if it’s worth staying in business) By addressing these concerns proactively, we can work towards a more sustainable and effective system that benefits all stakeholders.

PSG Consultation Questions

1 - If PSG rates are indexed (Option A), what should they be indexed to and why?

If PSG rates are indexed (Option A), they should be indexed to the Consumer Price Index (CPI) with a special acknowledgment that healthcare costs typically increase at a higher rate than general inflation.

Reasoning:

1. Healthcare-Specific Adjustments: While the CPI is a standard measure of inflation, it may not fully capture the unique and often higher cost increases experienced within the healthcare sector. Medical equipment, staff wages, facility rent, and regulatory compliance costs often outpace general inflation rates. Therefore, indexing the PSG rates to the CPI alone may not be sufficient to ensure fair compensation for healthcare providers.

2. Professional Association Input: To accurately account for the specific market conditions healthcare professionals face, it is essential that professional associations (e.g., physiotherapy, chiropractic, occupational therapy associations) provide input during the indexing process. These associations have direct knowledge of the sector's cost structure and can offer insights into factors such as salary trends, overhead expenses, and equipment costs, which may not be adequately reflected in the CPI.

While CPI indexing is a solid baseline, it should be supplemented with regular input from professional associations to adjust for the specific and often higher increases in healthcare costs. This approach would ensure that PSG rates remain fair, sustainable, and reflective of the actual market conditions within the Canadian healthcare sector.

2 - If PSG are moved to flat rates (Option B), how should those flat rates be determined and why?

The key issue with flat fees is that they oversimplify the complexities of healthcare. Healthcare is not a one-size-fits-all service, and trying to fit a variety of patient needs into a uniform fee structure is not only unrealistic but potentially harmful. Different patients require varying levels of care, and a flat rate could lead to under-treatment, longer recovery times, and poorer outcomes. Moreover, flat fees must be tied to a reasonable, transparent

underlying rate—ideally an hourly rate—so that both healthcare providers and patients receive fair treatment.

FSRA has not reviewed PSG rates in over a decade, and in the case of the MIG, it's been 15 years. While this might not have been illegal, it certainly hasn't been in the best interest of consumers, patients, or the auto insurance treatment framework. It's time to properly evaluate and adjust rates to reflect the realities of today's healthcare costs and needs.
If flat fees are to be considered, they must be linked to a fair hourly rate to ensure that healthcare professionals are adequately compensated, and patients are properly cared for. Arbitrary flat fees, without this critical context, will only lead to underpayment for professionals and diminished care for patients.

3 - Should rate increases (Option A or Option B) be staggered incrementally over a few years, or should it take place at once?

Rate increases should take place all at once.

Reasoning:

1. **Long Overdue Adjustment**: The current PSG rates have not kept pace with inflation and the rising costs within the healthcare sector for many years. As such, an immediate adjustment is necessary to correct for this long-standing issue and to bring compensation rates up to a fair and sustainable level.
2. **Restoring Fair Compensation**: Healthcare professionals have been subsidizing the system by accepting outdated rates that do not reflect the real costs of delivering care. Implementing the rate increase all at once will ensure that healthcare providers are fairly compensated for their services without further delay, helping to stabilize the system and retain qualified professionals.
3. **Immediate Impact on Quality of Care**: A one-time increase would provide an immediate boost to the resources available to healthcare professionals, allowing them to invest in better services, equipment, and staff. This, in turn, improves patient care and outcomes more quickly than a staggered approach would.
4. **Administrative Efficiency**: Implementing a single, comprehensive rate increase reduces the administrative burden and complexity associated with multiple, incremental adjustments over several years. It also provides clarity and stability for both healthcare professionals and insurers, helping them plan and adapt more effectively.

Given the urgent need for reform and the benefits of restoring rates to a fair level immediately, implementing the increase all at once is the most effective and fair approach.

4 - Should FSRA review fees regularly, and if so, at what frequency (i.e. annually, biennially etc.)?

Yes, FSRA should review fees regularly. The rates should be adjusted **annually** according to the CPI, similar to how FSRA adjusts other components of accident benefits on a yearly basis.

Reasoning:

1. **Annual CPI Adjustments**: Adjusting fees annually based on the CPI ensures that rates remain current and aligned with inflation, reflecting changes in the economy and preventing healthcare professionals from falling behind in compensation. This approach provides a consistent, predictable framework for both healthcare providers and insurers, helping to maintain fair remuneration.

2. **Formalized Triennial Review**: In addition to the annual adjustments, FSRA should conduct a more comprehensive, formalized review every **three years**. This review should involve consultation with professional associations to ensure that the rates accurately reflect the real costs and market conditions specific to healthcare. Professional associations can provide valuable insights into changes in the sector, such as rising overhead costs, evolving treatment protocols, and other factors not captured by the CPI alone.

By implementing this two-pronged approach—annual CPI-based adjustments and a formal triennial review with professional associations—FSRA can create a fair and responsive system that maintains alignment with both economic and sector-specific changes. This ensures that fees remain adequate, sustainable, and supportive of high-quality patient care.

5 - For Option C how often should insurers/HSPs meet to review/set maximum rates?

Option C sets healthcare professionals up to fail. The power imbalance between insurers and healthcare service providers (HSPs) cannot be ignored. Allowing insurers and HSPs to negotiate rates on their own, without proper oversight, unfairly tilts the scales in favour of insurers, who possess far greater financial resources and bargaining power.
In terms of how often insurers and HSPs should meet to review or set maximum rates, the answer is not about frequency, but fairness. The rates need to be set impartially and should be primarily pegged to a transparent and unbiased index, like what other provinces have done with MIG rates. Relying on an impartial index ensures that rates are set fairly across

the board, protecting healthcare professionals and patients from being disadvantaged by insurer-dominated negotiations.

Setting rates through insurer-led negotiations only deepens the power imbalance, leading to unfairly low compensation for HSPs. This results in providers being underpaid and patients receiving inadequate care, as clinics may be forced to cut corners or leave the auto insurance sector altogether. FSRA's role should be to ensure fairness in the system by maintaining a regulatory framework that protects the interests of all parties, especially patients who rely on timely and quality care.

By continuing to peg rates to an impartial index, FSRA can ensure sustainability and fairness in the system, rather than creating a structure where providers are at the mercy of insurers. Frequency of meetings between insurers and HSPs won't address the core issue; fair rate-setting and oversight will.

6 - Are there other options/considerations related to rates/fees that should be considered for the PSG?

Other important considerations related to rates/fees in the PSG include compensating for charting, telephone conversations initiated by adjusters, and additional paperwork requests like progress notes. Here's why these elements should be incorporated:

1. **Charting Care Activities:**

- **Compensation for Essential Work**: Healthcare professionals frequently perform necessary tasks such as charting, updating patient records, planning treatment strategies, and conducting other patient care activities outside of regular sessions, often after hours. These tasks are essential for ensuring the continuity and quality of care but are currently done without compensation.
- **Promoting Comprehensive Care**: By compensating healthcare providers for these activities, the PSG framework would recognize the full scope of work involved in patient care, encouraging thorough and detailed charting and care planning. This leads to improved patient outcomes and enhances the overall quality of service provided.
- **Aligning with Industry Best Practices**: Compensating for charting and after-hours work aligns with industry best practices, emphasizing the importance of accurate documentation, which is critical for legal compliance, patient safety, and collaboration among healthcare providers.

2. **Telephone Conversations with Adjusters:**

- **Time and Expertise**: Telephone conversations initiated by adjusters are often due to a lack of thorough document review, as it's easier for them to make a call when there is no cost associated. Attaching a fee to these calls would likely reduce their frequency, allowing healthcare professionals to focus more on patient care. If a fee were in place, conversations would be more likely to focus on integral aspects of the patient care process, warranting the professional expertise and time involved, both of which should be compensated fairly.
- **Consistency with Other Payor Systems**: Systems like the WSIB and private insurers already reimburse healthcare providers for these communications. Integrating similar compensation into the PSG framework would create consistency and fairness across different insurance and regulatory bodies, and it would help reduce the administrative burden on healthcare providers.
- **Enhanced Communication and Outcomes**: Compensating healthcare professionals for these interactions would facilitate better communication with adjusters, resulting in more timely and effective decision-making, ultimately improving patient care.

3. **Additional Paperwork Requests (e.g., Progress Notes):**

- **Necessary Part of Patient Management**: Progress notes and other paperwork requests are essential for documenting patient status, communicating with insurers, and updating treatment plans. These documents are often requested by insurers and require the healthcare professional's expertise and time to complete accurately.
- **Uncompensated Time and Effort**: Currently, healthcare professionals often fulfill these requests without compensation, adding to their workload without adequate recognition or remuneration. Compensating for these additional paperwork tasks ensures that professionals are paid for all aspects of their work that are essential to patient care.
- **Consistency with Standard Practices**: Many private insurers and other payor systems recognize the importance of such documentation and provide compensation for these services. Aligning the PSG framework with this practice would ensure fairness and consistency across the sector.

Incorporating compensation for charting, telephone conversations with adjusters, and additional paperwork requests like progress notes is vital for creating a fair and comprehensive PSG framework. These activities are integral to the delivery of high-quality healthcare, and compensating for them ensures that healthcare professionals are supported in their efforts to provide thorough and effective patient care. By aligning PSG rates with these considerations, the system would not only promote better outcomes for patients but also foster a more sustainable and efficient auto insurance treatment framework.

7 - Do you have any evidence that consumers are having difficulty obtaining the HSP care they need due to the existing PSG rates?

As reported in the October 13, 2022, HSP Market Conduct Activities Report (page 12), many businesses chose not to renew their licenses, citing that they "no longer deal with Statutory Accident Benefits Schedule (SABS) claimants." This statement includes only those contacted for late AIR payments and does not account for the broader number of providers who, despite paying their fees, have opted out due to the burdensome requirements. This indicates their first choice for care was no longer providing auto insurance related care.

This reduction in licensed providers impacts patient care, prolonging recovery times and increasing the risk of long-term disability and dependence on public healthcare and social services when local providers are unavailable. Ontario is nearing a tipping point where inefficient market oversight could lead to a generational miscalculation in healthcare access. It is crucial that we proactively address this issue now through this consultation, an opportunity for the Ministry of Finance to be forward-thinking and prevent potentially irreversible consequences.

8 - What are the key implementation considerations that must be taken into account for each option (i.e. timing, updates to billing systems, etc.)?

The key implementation considerations for each option include:

1. Timing and Decisive Action

- **Quick Implementation**: Changes, such as removing redundant licensing requirements, should be implemented decisively within the current year. This will allow healthcare professionals to save both time and money as they enter the new year, creating an immediate positive impact.
- **Positive Public Perception**: Rapid implementation will also reflect positively on the government, demonstrating its commitment to reducing administrative burdens and supporting healthcare professionals.

2.-Coordination with Fee Increases

- **Aligning Changes**: Coordinating the removal of licensing requirements with a simultaneous increase in professional service fees will build goodwill from

healthcare professionals and the healthcare business community. This alignment shows a comprehensive and supportive approach, enhancing the positive perception of government efforts.
- **Generating Goodwill**: By addressing both regulatory and financial concerns simultaneously, the government fosters a more motivated and appreciative healthcare workforce, who will likely attribute these positive changes to the government's actions.

3. Reduction in Red Tape

- **Streamlining Processes**: By eliminating unnecessary administrative burdens, the government empowers healthcare professionals to focus on their practice, increasing their satisfaction and commitment to the sector. The reduction of red tape will also increase efficiency in the system, leading to improved outcomes for consumers and stakeholders alike.
- **Building Trust and Motivation**: These changes will result in a workforce that feels motivated and supported, creating a sense of gratitude towards the government for actively improving their work environment.

4. Moratorium on New Entrants

- **Two-Year Monitoring Period**: A two-year moratorium on new entrants into the system should be established to closely monitor the effects of these changes. This will allow for a controlled and safe environment, ensuring that the reforms have the intended positive impact without compromising consumer protection.
- **Perception of Prudence and Safety**: This moratorium will demonstrate the government's careful approach, showing that it is not only proactive but also cautious and wise in safeguarding the integrity of the framework for both consumers and service providers.

By executing these strategies swiftly, the government can effectively capitalize on the positive energy generated by these changes, ensuring the goodwill of healthcare professionals and the business community while maintaining safety and security for consumers.

9 - How can FSRA help to ensure that any changes to the PSGs are communicated to HSPs, insurers, consumers and other stakeholders?

The usual communication channels will be sufficient for ensuring that any changes to the PSGs are effectively communicated to HSPs, insurers, consumers, and other stakeholders. Regular updates through email bulletins, newsletters, and official websites, along with

direct communication with professional associations, will help ensure that all parties are informed in a timely manner.

10 - Are there other considerations which have been missed that should be taken into account as part of the PSG review?

One key consideration that seems to have been overlooked in the PSG review is the issue of market entry and its impact on the sustainability of the auto insurance rehabilitation market. A significant challenge arises from external forces and unregulated entities entering the market, often causing disproportionate issues compared to regulated healthcare professionals.

To maintain the integrity of the system, I propose introducing limited, short-term barriers to entry for businesses seeking Health Service Provider (HSP) licensing that are not owned or controlled by regulated healthcare professionals. By focusing FSRA's oversight on clinics that are not governed by healthcare colleges, FSRA can better allocate its resources and provide stronger oversight in areas that have historically been problematic.

Additionally, removing the licensing requirement for clinics owned by regulated healthcare professionals would streamline the process, as these professionals are already subject to oversight by their respective health colleges. This would free up FSRA staff to concentrate on more pressing issues and challenges that may arise from the proposed changes in this consultation.

Implementing a two-year moratorium on new entrants into the HSP and HCAI systems—except for clinics regulated by healthcare colleges—would provide short-term stability and allow the system to adjust to new regulations. Moreover, requiring HCAI Authorizing Officers to have a minimum of five years of professional rehabilitation experience would ensure higher standards of care and professionalism across the industry.

These considerations are crucial to ensuring the market remains sustainable and stable during this transition. Significant increases to the PSG and MIG rates are essential to prevent a collapse of the market that serves auto insurance consumers. By addressing these concerns, we can create a more effective and fair system for all stakeholders involved.

MIG Consultation Section:

History of the MIG:

In 2002, Bill 198 (Keeping the Promise for a Strong Economy Act) authorized the Superintendent of Financial Services to issue guidelines for treatment, goods, and services under the Statutory Accident Benefits Schedule. This decision empowered a financial regulatory body—not healthcare professionals—to design treatment frameworks primarily to cap costs rather than provide appropriate care. This was a bad idea, and we are paying the price for it today.

Introduction of Pre-approved Framework Guidelines for Whiplash Associated Disorder Grade I and II Injuries With or Without Complaint of Back Symptoms

To the attention of all insurance companies licensed to transact automobile insurance in Ontario

As part of the reforms to the current auto insurance system, Bill 198 *(Keeping thePromise for a Strong Economy Act (Budget Measures)*, 2002 authorizes the Superintendent to issue guidelines relating to treatment, goods and services associated with medical and rehabilitation benefits under the Statutory Accident Benefits Schedule.

With this Bulletin, the Superintendent is introducing Pre-approved Framework (PAF) Guidelines to the accident benefits system. The PAF Guidelines provide specific protocols for accessing treatment for certain impairments without requiring prior insurer approval in order to commence treatment.

The PAF Guidelines address whiplash associated disorders (WAD I and WAD II), the most common conditions resulting from an auto accident. Insured persons who do not have an impairment which fits within these Guidelines may continue to use the Treatment Plan process outlined in the Statutory Accident Benefits Schedule.

The PAF Guidelines provide an overview of the expected course of treatment with a focus on the insured person maintaining normal daily activities; they are not clinical guidelines. The PAF Guidelines set out block fees which will be paid depending on the duration of the treatment. Some additional fees will be chargeable in specified circumstances. Upon completion of treatment, a final report will be prepared for the insurer which will indicate the insured person's outcomes from treatment.

The PAF Guidelines represent a consensus agreement between auto insurers and health care providers and may be revised over time based on the parties' experience.

The PAF Guidelines are effective for all accidents occurring on and after October 1, 2003.

Sincerely,

Bryan P. Davies
Chief Executive Officer and
Superintendent of Financial Services

July 14, 2003

The approach assumed that injuries could be managed not only within fixed budgets, but within frameworks like the Pre-Approved Framework (PAF) and, later, the Minor Injury Guideline (MIG) implemented without clinical validation, scientific review, or evidence of positive outcomes for injured Ontarians.

These caps have added layers of bureaucracy, driving up costs while failing to meet the real needs of injured people.

The 12-week MIG, like the 6-week PAF before it, is not a treatment program. It imposes a $3,500 cap on a broad range of injuries without clinical rationale, based loosely on findings from the Bone and Joint Decade Task Force on Neck Pain. No one is taught in school how to "treat MIGs" because it is simply a fee cap masquerading as a treatment guideline.

Today’s costly and ineffective recovery programs are symptoms of a flawed system that prioritized financial limits over patient care, a misguided foundation the previous government continued to build upon at society’s expense.

The MIG is based on the concept of how a functional restoration model of care is designed to enable injured individuals to return to specific activities, such as work or other daily tasks. Its primary focus is not to achieve full recovery but more so on enabling the individual to participate in chosen activities. Once the individual can successfully begin to engage in these activities, the program is deemed successful.
https://www.canadianunderwriter.ca/features/cc-minor-injury-guideline-refresher/

The creation of the MIG and, before it, the PAF, were never aligned with the goals of the SABS, which aims to help injured people return to their full pre-accident level of function.

The MIG and PAF overly restrict therapists' clinical judgment, compromising the quality of care. While policy limits for “minor injuries” have a purpose, attempting to impose restrictive programs on clinicians was misguided and in the opinion of many clinicians harmed recovery. A simple fee cap for minor injuries would have been far better than having financial services providers dictate care programs that ultimately undermine effective treatment.

We should remove the 12-week MIG framework guidelines altogether which would be sensible, since the real benefit of raising the MIG rates is to allows clinicians to provide more care within it to enable patient recovery. PAF and MIG are failed experiments, and they are unnecessary if all you’re really wanting is a fee cap then impose a fee cap without restrictions on what can be delivered during the 12-week period. We have fee limits for non-catastrophic and catastrophic impairments without “treatment” frameworks and it is my opinion that these treatment frameworks have harmed care delivery and increased red tape without any real benefit.

Removing the MIG 12-week framework is something that should be considered because It takes a unique kind of confidence to keep betting on a bad idea when all signs scream it’s failing.

The Riverboat Gamble: George Cooke’s 2010 Predictions Realized in the Minor Injury Guideline Framework

In 2010, George Cooke, then president and CEO of The Dominion, cautioned against Ontario's approach to categorizing injuries under the new Minor Injury Guideline (MIG). He suggested that the real solution lay not in tightening the catastrophic impairment definition

but in ensuring that only truly minor injuries were subject to reduced caps. His concern was clear: misclassifying serious injuries as minor for administrative convenience risked leaving patients without access to adequate treatment coverage and would ultimately drive up costs.

Cooke's metaphor of "riverboat gambling" captured the pricing uncertainty imposed on insurers forced to make educated guesses about costs due to the framework's lack of clarity. Thirteen years later, the impacts of this prediction resonate strongly. Ontario's auto insurance landscape shows that the administrative and financial burdens Cooke feared are indeed a reality. Instead of the intended reduction in system costs, the rigid minor injury caps have introduced inefficiencies, increased administrative expenses, and constrained patient care, as insurers benefit from inflated premiums that consumers must bear.

This consultation highlights the unintended consequences of failing to limit minor injury classifications effectively, echoing Cooke's early recommendations. Today, the regulatory environment has accumulated layers of oversight without improving fraud detection or patient outcomes, reaffirming that true reform lies in simplifying these systems. Aligning definitions and treatment paths to reflect real-world injury complexity is necessary to prevent further erosion of patient care and ensure the Minor Injury Guideline serves its purpose without penalizing those in genuine need of more comprehensive treatment.

https://www.canadianunderwriter.ca/features/riverboat-gambling/

Why Raising the MIG Fee CAP is required:

To improve patient outcomes and reduce costly disputes, it is essential to revisit and increase the funding model within the Minor Injury Guideline (MIG). The current fees were set arbitrarily in 2010, leading to disagreements over whether the MIG can provide enough treatment or is suitable for a vast majority of patient injuries back then.

Since the Minor Injury Guideline (MIG) in Ontario has remained unchanged since 2010, and unlike other provinces, Ontario had not accounted for inflation by indexing the guideline. The block fees no longer cover the necessary number of treatments to substantially address most injuries. Every year, the financial restrictions of the MIG make it harder for patients to receive the appropriate amount of care required for recovery.

Regardless of what financial services wants people to believe injuries still need a significant number of interventions to heal, but as costs rise, fewer treatments can be provided within the block fees.

The MIG in its' current form and rate leads to more disputes, as healthcare professionals argue that patients will not reach maximum medical recovery under the outdated fee caps.

The ultimately drives up costs through increased disputes and prevents consumers from getting the care they need to recover fully within the MIG.

Every other jurisdiction that introduced the IBC created MIG indexed the MIG to inflation, Ontario was the only one that did not. As a result, our Ontario MIG has remained at 3500 while other jurisdictions continue to be indexed.

We should not only consider updating the funding envelope for what should be referred to as **level one injuries**, but we should remove the unscientific 12-week framework altogether. By updating the funding model, we can decrease the frequency of disputes, especially with the introduction of a more streamlined dispute resolution process that could save both time and money. Ontario has the lowest MIG in Canada. The chart below is from 2022, and the current rates are higher with Nova Scotia having a MIG in 2024 of $10402.

How Ontario's Minor Injury Guideline Compares To Other Provinces (Ours is the Lowest)

Province	Administration	Minor Injury Cap	Indexed?
NS	Private	$9,300	Yes
NB	Private	$8,638	Yes
PEI	Private	$8,358	Yes
BC	Public	$5,831*	Yes
AB	Private	$5,488	Yes
MB	Public	Not applicable	Not applicable
NL	Private	No Cap (awards subject to $5,000 deductible)	Not applicable
ON	Private	$3500.00	No
QC	Public	Not applicable	Not applicable
SK	Public	No Cap (awards subject to $5,000 deductible)	Not applicable

Figure 1: MIG per Province - lowest MIG in CANADA is Ontario

The Issue with MIG Disputes

When healthcare professionals submit treatment plans instead of requesting a MIG often it's with the knowledge the MIG does not provide enough care time to allow recovery to occur fully or the patient has pre-existing conditions that will prevent recovery within the MIG, or the patient requires attendant care that is precluded from the MIG.

Typically, in these situations adjusters will send the patient for an insurance exam within the insurance companies closed preferred provider network of insurance examiners.

So, when a physiotherapist determines that a patient will not achieve maximum recovery within the MIG and recommends treatment beyond the guideline or instead of the guideline, the decision is typically handed off to a preferred provider physician examiner who lacks any hands-on rehabilitation expertise since they are not rehabilitation professionals.

These assessors focus solely on whether an injury is "minor" without considering other health issues or challenges the person might have, this leads to bad assessment results that are eventually challenged and often overturned. Yet in the short term the patient will not get adequate care or support because their full situation isn't being looked at, which can make recovery take longer or even make things worse.

In the end, ignoring these extra health problems can make the whole process more expensive, hurt patients by delaying or denying the care they need, and make people lose trust in the system.

Failure to recover, means that despite treatment stopping at 2200 or 3500 dollars for the MIG the patient won't magically get better or disappear. They will seek other pain control measures, and they begin a lawsuit.

Ironically, one of the most interesting conversations I've had was with a former adjuster who, after experiencing a car accident herself, couldn't fully recover within the limitations of the MIG. Though she wasn't my patient, it was her personal experience that reshaped her understanding of the auto insurance treatment system. She opined about how when she was younger she believed that her education from insurers of car accident injuries was that the people simply had to "walk it off".

Even patients recovering from co morbidities such as strokes have been denied extended rehabilitation based on the motor vehicle related injury being classified as "minor", no consideration is given anymore to red flags or yellow flags to recovery which used to accompany the pre-approved framework (PAF) but were omitted in the MIG guideline.

Which also make us wonder why was it that the PAF had red flags and yellow flags to ensure patients could be excluded from the framework, but the MIG removed those as important treatment considerations altogether?

Low fee caps and expensive dispute processes that focus on strict injury definitions, focusing on keeping rates low as a primary KPI rather than more meaningful metrics like recovery, return to work, chronic pain prevention, and overall patient well-being. Malign auto insurance consumers and ultimately lead to greater long-term costs.

Revisiting and revising the funding model is not only about fairness, but also about reducing system inefficiencies and improving patient outcomes. By addressing these flaws, we can ensure a more equitable, sustainable and effective system for all parties involved and decrease costs in the long run.

MIG Fee was set arbitrarily without consultation with Healthcare Associations or Assessment of Economic Impact

As noted in the Standing Committee on General Government Monday May 28, 2012 https://www.ola.org/en/legislative-business/committees/general-government/parliament-40/transcripts/committee-transcript-2012-may-28

In 2012 the Ontario Physiotherapy Association in a presentation to the Ontario Provincial Parliament Stated:

> "Prior to 2010, patients with neck injuries—so whiplash and associated disorders—received treatment under the pre-approved framework guideline. Reforms brought us an expanded version of this guideline that now includes the majority of soft-tissue injuries. Whether the patient has a sprained ankle and some slight neck pain or has multiple soft-tissue injuries, this all goes under the minor-injury cap.
>
> While the majority of people will likely get better under this framework, there's no exemption for those people who require additional treatment once the minor-injury guideline treatment and the total cap of $3,500 has been reached. It should be noted here that the $3,500 is a relatively arbitrary fee. It's not something that was based on—the treatment framework itself is based on scientific evidence, but not the amount. So we may have gone from a program that is a little too narrow in its scope with the pre-approved framework to one that might be a little too broad."
>
> And
>
> "providers are finding that insurers are using this discretion to deny what could be reasonable treatment without the opportunity for a patient to get a second opinion."

Ontario's $3,500 cap under the Minor Injury Guidelines (MIG) is both unfair and economically short-sighted. Ethically, it denies patients necessary care by imposing an arbitrary limit that doesn't account for individual needs within an untested framework, leading to incomplete recoveries and a lack of access to valid second opinions. Its' effectiveness has never been reviewed but economically we can see this approach has increased long-term costs for insurers, as untreated injuries often worsen, resulting in chronic conditions that require more extensive and expensive treatment later on. A more flexible system that addresses real cost drivers would better serve both patients and insurers, reducing overall costs while promoting fair, effective care.

Concerns Regarding FSRA's Reported Average MIG Claim Amount as $1,258

I have significant concerns about the data presented by the Financial Services Regulatory Authority of Ontario (FSRA) and the Insurance Bureau of Canada (IBC), which report the average Minor Injury Guideline (MIG) claim as $1,258 for the first half of 2023 (as noted on page 25 of the SABS consultation). This figure is used to justify not increasing the MIG, but it appears inconsistent with real-world experiences. Or the indexed MIG costs and utilization in other provinces.

The MIG allows up to $3,500 for treatment and based on feedback from having asked over one hundred clinicians and my own experience, patients typically utilize the full amount. Even in minimal cases—which are rare and may involve only an initial assessment, one week of care, and a discharge report totaling $488.75—the average claim amount should be higher. For example, averaging two patients—one with minimal costs ($488.75) and another using $2,200—the average claim would be $1,344.38, already exceeding the reported $1,258. If a patient attends treatment for only the first month, which is more common, the average cost is approximately $1,695.

From a practical standpoint, the reported average MIG claim of $1,258 does not align with actual treatment costs and clinical experiences. This discrepancy suggests that the data is be flawed or inaccurately classified.

Additionally, the data sample used by FSRA represents less than 1% of yearly claims costs, raising concerns about its reliability for informing policy decisions. The significant mathematical inconsistencies and the small data set indicate that the conclusions drawn may be unreliable and completely inappropriate for broader policy applications.

Bad data, small sample sizes, perception polls asking people to imagine what would happen if they were in an accident, all make me believe people are grasping at anything to prove a point and justify the unjustifiable.

I caution policymakers against basing proposals or decisions on such limited and potentially inaccurate data. A more comprehensive and accurate analysis is necessary to ensure that policies truly reflect the realities in Ontario. Until this particular data can be fully explained and traced back to its source, it should not serve as the foundation for policy changes.

Upon reviewing how the Health Claims for Auto Insurance (HCAI) system codes the GAP codes for MIG patients, it appears that a flaw in FSRA's observation may stem from the HCDB data not including the $1,300 extension. This extension is not coded with the "M" notation and isn't easily allocated to MIG patients HCDB dataset. Furthermore, there doesn't seem to be a clear distinction in how this extension is coded differently from other treatments outside of the MIG which intermingles treatment within the MIG CAP with non MIG Treatment. It seems coding issues are contributing to inaccuracies in the data, suggesting that the mathematical figures presented may not be accurate.

It is disappointing that when the FSRA should be putting its best foot forward to address systemic issues within the auto insurance and healthcare framework, it presents data and conclusions that do not align with practical realities. The apparent discrepancies in the reported average MIG claim amount, potential coding issues, and historical lack of awareness of its' role in setting healthcare remuneration all point to a need for a more critical and thorough examination of the data and the FSRA's role.

I urge the FSRA to:

1. **Re-evaluate Data Sources**: Conduct a comprehensive review of data collection and coding processes to ensure that all relevant costs, including the $1,300 extension, are accurately captured and attributed.
2. **Engage with Healthcare Professionals**: Collaborate closely with clinicians and other stakeholders to gain a deeper understanding of the practical implications of policies and gather firsthand insights into the realities faced by claimants.
3. **Address Systemic Issues Critically**: Move beyond surface-level analyses and critically examine the systemic issues contributing to rising costs and inefficiencies within the treatment framework to benefit consumers of auto insurance.
4. **Enhance Transparency and Accountability**: Acknowledge past oversights and commit to improving transparency in decision-making processes to rebuild trust with consumers and professionals.

Response to MIG Proposed Options

Response to Option A – MIG: Index the Rates in the Fee Schedule

While indexing the MIG fee schedule rates is a step in the right direction, it does not sufficiently address the fundamental issues within the Minor Injury Guideline (MIG). To truly enhance patient care and system efficiency, I propose increasing the MIG limit to $15,000 and adjusting the Professional Services Guideline (PSG) rates to reflect current healthcare costs. I also suggest removing the block billing charges within the MIG and allowing the healthcare professional the independence to practice their professions to the best of their ability within the MIG limit.

Therefore, the total MIG cap should be $15,000, with the current $2,200 portion increased proportionally to $9,430. Therapists should have the flexibility to use these funds as they see fit during the first 12 weeks of treatment, rather than being constrained by the restrictive blocks that negatively impact patient outcomes. If FSRA wishes to contest the claim that these blocks harm outcomes, they should conduct a study—something that should have been done 10 years ago. Currently, FSRA's lack of data and their questionable presentation of the average MIG costing less than $1,300 raises concerns about the reliability of any information they provide on the MIG.

Rationale for Increasing the MIG Limit to $15,000

1. Comprehensive Patient Care: The current $3,500 cap is inadequate for patients with multiple injuries or those requiring extended care. It is no longer an effective option to prevent chronic pain. Stopping care at a monetary limit does not mean the patient has recovered it simply means a monetary limit has been met and nothing further will be paid unless a long and protracted dispute process begin. Financial services has not monitored recovery outcomes but as a clinician who sees the offloading of care onto the public system the unrecovered don't go away, they become chronic and are picked up by public healthcare dollars and then they receive a settlement after years of unemployment

By increasing the limit to $15,000, and we ensure that patients have access to the necessary treatments for full recovery, reducing the likelihood of chronic pain and long-term disabilities and increased reliance on ODSP and settlements.

2. Reducing Legal Issues and Chronic Pain: Adequate funding for treatment means more patients can recover fully within the MIG framework, decreasing the need for legal interventions and the development of chronic conditions. This proactive approach minimizes long-term costs for both the healthcare system and insurers.

3. Reflecting Actual Healthcare Costs: Since the MIG rates were set in 2010, healthcare costs have significantly increased. Adjusting the limit to $15,000 aligns with current market rates and ensures that healthcare providers can deliver quality care without financial strain.

Need for Increasing PSG Rates

1. Fair Compensation for Healthcare Providers: In 1996, healthcare providers were compensated up to $120 per session. Adjusted for healthcare inflation—which exceeds the general Consumer Price Index (CPI)—the rates should be substantially higher today. Increasing PSG rates acknowledges the true cost of delivering care and supports the sustainability of healthcare practices.

2. Retention of Healthcare Professionals: Inadequate compensation and increased administrative burdens have led many providers to exit the auto insurance sector. By offering fair rates, we can retain skilled professionals, ensuring patients have access to experienced care providers.

3. Enhancing Patient Outcomes: Fairly compensated providers can focus more on patient care rather than administrative tasks or financial viability. This leads to better treatment plans, more attentive care, and improved recovery rates.

Addressing Consultation Considerations

- Market-Rate Compensation: Adjusting MIG and PSG rates ensures healthcare service providers (HSPs) are compensated at market rates, consistent with other payor systems like the Workplace Safety and Insurance Board (WSIB).

- Impact on Consumers: While most injuries fall under the MIG, increasing the limit and rates benefits consumers by providing access to comprehensive care, reducing the risk of chronic issues, and potentially lowering long-term insurance premiums due to fewer extended claims and legal disputes.

- Stakeholder Feedback: The absence of significant stakeholder feedback may stem from disengagement due to prolonged underfunding. Proactively addressing rate increases demonstrates a commitment to improving the system for all parties involved.

- Broader MIG Issues: Raising the MIG limit to $15,000 addresses broader concerns, such as the cost of treating patients with multiple injuries and simplifies the classification between MIG and non-MIG cases, reducing disputes and administrative costs.

- Utilization of MIG Benefits: The claim that most consumers do not reach the $3,500 threshold overlooks that insufficient funding often forces patients to discontinue necessary treatment. Increasing the limit ensures patients can complete their recommended treatment plans, leading to better health outcomes.

Conclusion

We find ourselves in a situation where many patients have not had the opportunity to fully recover due to insufficient funding within the MIG framework. This has led to increased chronic pain cases, higher societal costs, and more legal disputes. By increasing the MIG limit to $15,000 and adjusting PSG rates to reflect actual healthcare costs, we can:

- Provide patients with the necessary resources for complete recovery.
- Reduce the incidence of chronic pain and long-term disabilities.
- Minimize legal disputes and administrative burdens.
- Retain and fairly compensate healthcare professionals.
- Improve overall system efficiency and sustainability.

Investing in patient care upfront not only enhances individual health outcomes but also reduces long-term costs for insurers and the public healthcare system. It is a proactive approach that benefits all stakeholders and leads to a more effective and equitable auto insurance rehabilitation system.

MIG Consultation Questions:

1. If MIG rates are indexed (Option A), what should they be indexed to and why?

If MIG rates are indexed (Option A), they should be indexed to the Consumer Price Index (CPI) with a special acknowledgment that healthcare costs typically increase at a higher rate than general inflation.

The total MIG cap should be $15,000, with the current $2,200 portion increased proportionally to $9,430. Therapists should have the flexibility to use these funds as they see fit during the first 12 weeks of treatment, rather than being constrained by the restrictive blocks that negatively impact patient outcomes. If FSRA wishes to contest the claim that these blocks harm outcomes, they should conduct a study—something that should have been done 10 years ago. Currently, FSRA's lack of data and their questionable presentation of the average MIG costing less than $1,300 raises concerns about the reliability of any information they provide on the MIG.

Reasoning:

1. Healthcare-Specific Adjustments: While the CPI is a standard measure of inflation, it may not fully capture the unique and often higher cost increases experienced within the healthcare sector. Medical equipment, staff wages, facility rent, and regulatory compliance costs often outpace general inflation rates. Therefore, indexing the MIG rates to the CPI alone may not be sufficient to ensure fair compensation for healthcare providers.

2. Professional Association Input: To accurately account for the specific market conditions healthcare professionals face, it is essential that professional associations (e.g., physiotherapy, chiropractic, occupational therapy associations) provide input during the indexing process. These associations have direct knowledge of the sector's cost structure and can offer insights into factors such as salary trends, overhead expenses, and equipment costs, which may not be adequately reflected in the CPI.

While CPI indexing is a solid baseline, it should be supplemented with regular input from professional associations to adjust for the specific and often higher increases in healthcare costs. This approach would ensure that MIG rates remain fair, sustainable, and reflective of the actual market conditions within the Canadian healthcare sector.

2. Should rate increases (Option A) be staggered incrementally over a few years, or should it take place at once?

Rate increases should take place all at once. The total MIG cap should be $15,000, with the current $2,200 portion increased proportionally to $9,430. Therapists should have the flexibility to use these funds based on their clinical judgement during the first 12 weeks of treatment, rather than being constrained by the restrictive blocks that negatively impact patient outcomes. If FSRA wishes to contest the claim that these blocks harm outcomes, they should conduct a study—something that should have been done 10 years ago. Currently, FSRA's lack of data and their questionable presentation of the average MIG costing less than $1,300 raises concerns about the reliability of any information they provide on the MIG.

Reasoning:

1. **Long Overdue Adjustment**: The current MIG rates have not kept pace with inflation and the rising costs within the healthcare sector for many years. As such, an immediate adjustment is necessary to correct for this long-standing issue and to bring compensation rates up to a fair and sustainable level.
2. **Restoring Fair Compensation**: Healthcare professionals have been subsidizing the system by accepting outdated rates that do not reflect the real costs of delivering care. Implementing the rate increase all at once will ensure that healthcare providers are fairly compensated for their services without further delay, helping to stabilize the system and retain qualified professionals.
3. **Immediate Impact on Quality of Care**: A one-time increase would provide an immediate boost to the resources available to healthcare professionals, allowing them to invest in better services, equipment, and staff. This, in turn, improves patient care and outcomes more quickly than a staggered approach would.
4. **Administrative Efficiency**: Implementing a single, comprehensive rate increase reduces the administrative burden and complexity associated with multiple, incremental adjustments over several years. It also provides clarity and stability for both healthcare professionals and insurers, helping them plan and adapt more effectively.

Given the urgent need for reform and the benefits of restoring rates to a fair level immediately, implementing the increase all at once is the most effective and fair approach.

3. Is the existing block fee structure/amounts for pre-approved MIG treatment appropriate? Why or why not?

No, the existing block fee structure and amounts for pre-approved Minor Injury Guideline (MIG) treatment are not appropriate. All blocks need to be raised proportionally to reflect current healthcare costs and inflation.

Reasons:

1. **Inadequate Compensation Due to Inflation:**
   - The MIG fee schedule rates have not been updated since the MIG was introduced in 2010.
   - Over the past decade, healthcare costs have increased significantly due to inflation, higher operational expenses, and rising costs of medical supplies and staffing.
   - Without proportional increases, healthcare providers are effectively receiving less compensation in real terms, making it financially challenging to offer quality care.
2. **Impact on Patient Care and Outcomes:**
   - Insufficient funding limits the ability of healthcare providers to deliver comprehensive treatment plans.
   - Patients may not receive the full extent of care needed for optimal recovery, increasing the risk of chronic pain and long-term disabilities.
   - By raising the block fees, patients are more likely to recover fully within the MIG framework, reducing the incidence of prolonged health issues.
3. **Retention of Healthcare Professionals:**
   - Many clinicians are exiting the auto insurance rehabilitation sector due to inadequate compensation and increased administrative burdens.
   - Raising the block fees proportionally would help retain skilled professionals, ensuring patients have access to necessary treatments and expertise.
4. **Alignment with Other Payor Systems:**
   - Other third-party payor systems in Ontario, such as the Workplace Safety and Insurance Board (WSIB), have increased healthcare provider fees to match market rates. AS related to the needs of their programs. It's important to note the WSIB goals are significantly different from MVA rehabilitation goals and the injuries are less complex.
5. **Reduction in Legal Issues and Chronic Pain Cases:**
   - Adequate funding for treatment reduces the likelihood of patients developing chronic conditions that require legal intervention or long-term care.
   - Investing in appropriate care upfront minimizes the need for costly legal disputes and reduces strain on the public healthcare system.
6. **Support for Multiple Injuries and Complex Cases:**
   - The existing block fees do not adequately cover cases where patients have more than one injury or require extended care.
   - Proportionally increasing the block fees ensures that treatment plans can be tailored to individual patient needs without financial constraints.

Conclusion:

Proportionally raising all block fees within the MIG is essential to:

- **Ensure Fair Compensation:** Align provider fees with current market rates and operational costs.
- **Enhance Patient Care:** Provide sufficient resources for comprehensive treatment, leading to better recovery outcomes.
- **Maintain System Sustainability:** Retain healthcare professionals within the sector and reduce long-term costs associated with chronic conditions and legal disputes.
-

By adjusting the block fee structure to reflect inflation and current healthcare costs, we can create a more effective and equitable system that benefits patients, providers, and insurers alike.

4- Should FSRA review MIG rates regularly, and if so, at what frequency (i.e. annually, biennially etc.)?

Yes, FSRA should review MIG rates regularly. The MIG rates should be adjusted annually based on inflation, as all other provinces index their adjustments to inflation rates.

Reasoning:
1. Consistency with National Standards: Indexing MIG rates annually according to inflation aligns Ontario's system with the practices of other provinces. By doing so, FSRA ensures that the system remains consistent and competitive across the country, preventing discrepancies that may affect the availability and quality of care.

2. Keeping Up with Rising Costs: Healthcare costs often increase at a rate higher than general inflation. Adjusting the rates annually helps ensure that the compensation for services under the MIG keeps pace with these rising costs, allowing healthcare providers to sustain high-quality care and remain incentivized to participate in the system.

3. Avoiding Long-Term Discrepancies: An annual review and adjustment process prevents the accumulation of disparities between costs and compensation. Without regular updates, the gap between what healthcare providers need to operate effectively and what they are paid grows, leading to decreased participation in the system and a decline in service quality.

4. Three-Year Comprehensive Review: In addition to the annual CPI-based adjustment, FSRA should conduct a comprehensive review every three years in collaboration with professional associations. This review would consider factors beyond inflation, such as changes in the cost of healthcare delivery, patient needs, and service trends, ensuring that the MIG rates are adequate and reflective of current market conditions.

By implementing both an annual inflation-based adjustment and a triennial comprehensive review, FSRA can create a responsive, fair, and sustainable system that supports healthcare providers and maintains the quality of care for accident victims.

5 Are there other options/considerations related to rates/fees that should be considered for the MIG?

A review of the MIG itself is long overdue. LEAN operations require revisiting utilization and assessing the performance and if the same can be accomplished more simply. The original amount set for the MIG and the blocks were arbitrary and has not kept pace with the realities of patient care or rising healthcare costs. We need to assess whether the MIG is truly serving its intended purpose or if it's simply adding extra red tape that burdens healthcare providers without improving patient outcomes.

One of the core issues with the MIG is that it acts as a fee cap, but within that cap, therapists should have the flexibility to create individualized treatment plans based on the needs of their patients. Rather than rigid guidelines that restrict treatment options, why not allow healthcare professionals to use their clinical judgment to design appropriate care within the existing fee cap? This would improve efficiency, reduce administrative burden, and lead to better patient care, as it would allow therapists to provide the right treatment at the right time without unnecessary constraints.

By revisiting the structure of the MIG and granting more autonomy to therapists, we can ensure that the system benefits both patients and healthcare providers, while still maintaining cost control.

6. Do you have any evidence that consumers are having difficulty obtaining the HSP care they need due to the existing MIG rates?

As reported in the October 13, 2022 Market Conduct Activities Report (page 12), many businesses chose not to renew their licenses, citing that they "no longer deal with Statutory Accident Benefits Schedule (SABS) claimants." This statement includes only those contacted for late AIR payments and does not account for the broader number of providers who, despite paying their fees, have opted out due to the burdensome requirements.

This reduction in licensed providers impacts patient care, prolonging recovery times and increasing the risk of long-term disability and dependence on public healthcare and social services when local providers are unavailable. Ontario is nearing a tipping point where inefficient market oversight could lead to a generational miscalculation in healthcare access. It is crucial that we proactively address this issue now through this consultation, an opportunity for the Ministry of Finance to be forward-thinking and prevent potentially irreversible consequences.

7. What are the key implementation considerations that must be taken into account for each option (i.e. timing, updates to billing systems, etc.)?

For healthcare professionals, the key implementation considerations for each option, such as timing and updates to billing systems, will not pose significant challenges. Healthcare professionals are already accustomed to adjusting fees and adapting to changes in the billing process, and this would be no different.

Given their familiarity with evolving systems and regulatory requirements, the transition should be smooth, provided that clear communication and guidance are offered in advance. The necessary updates to billing systems can be efficiently handled by most clinics and practices, especially with the support of existing software providers.
Timely implementation is crucial to avoid any disruptions in service, but from the healthcare professionals' perspective, the adaptability to these changes is expected to be seamless.

8. How can FSRA help to ensure that any changes to the PSGs are communicated to HSPs, insurers, consumers and other stakeholders?

This question is repeated from the PSG section, although referring to PSG I will assume it is meant to refer to changes to the MIG, irregardless the answer remains the same.

The usual communication channels will be sufficient for ensuring that any changes to the MIG are effectively communicated to HSPs, insurers, consumers, and other stakeholders. Regular updates through email bulletins, newsletters, and official websites, along with direct communication with professional associations, will help ensure that all parties are informed in a timely manner.

9. Are there other considerations which have been missed that should be taken into account as part of the MIG review?

One key consideration that seems to have been overlooked in the MIG review is the issue of market entry and its impact on the sustainability of the auto insurance rehabilitation market. A significant challenge arises from external forces and unregulated entities entering the market, often causing disproportionate issues compared to regulated healthcare professionals.

To maintain the integrity of the system, I propose introducing limited, short-term barriers to entry for businesses seeking Health Service Provider (HSP) licensing that are not owned or controlled by regulated healthcare professionals. By focusing FSRA's oversight on clinics that are not governed by healthcare colleges, FSRA can better allocate its resources and provide stronger oversight in areas that have historically been problematic.

Additionally, removing the licensing requirement for clinics owned by regulated healthcare professionals would streamline the process, as these professionals are already subject to oversight by their respective health colleges. This would free up FSRA staff to concentrate on more pressing issues and challenges that may arise from the proposed changes in this consultation.

Implementing a two-year moratorium on new entrants into the HSP and HCAI systems—except for clinics regulated by healthcare colleges—would provide short-term stability and allow the system to adjust to new regulations. Moreover, requiring HCAI Authorizing Officers to have a minimum of five years of professional rehabilitation experience would ensure higher standards of care and professionalism across the industry.

These considerations are crucial to ensuring the market remains sustainable and stable during this transition. Significant increases to the PSG and MIG rates are essential to prevent a collapse of the market that serves auto insurance consumers. By addressing these concerns, we can create a more effective and fair system for all stakeholders involved.

Balancing Patient Care and Legal Risks in Auto Insurance

Reforming Insurance Treatment Frameworks

The current Statutory Accident Benefits Schedule (SABS) in Ontario is failing the very people it was designed to protect. Consumers are being harmed by a system that is both unfair and inefficient, ultimately costing everyone more. When accident victims can't access the care they need due to unjust adjusting decisions, they're often forced to seek legal help. This not only delays their recovery but also adds financial strain during an already difficult time, leading to increased litigation and soaring costs for all.

Healthcare professionals dedicated to helping these individuals are becoming increasingly demoralized. The Financial Services Regulatory Authority (FSRA) seems indifferent to the ethical concerns raised by those on the front lines of patient care. This information should be part of their mandate to obtain from healthcare professionals. While strict timelines are imposed on healthcare providers, insurance adjusters frequently miss their deadlines without consequence or deny treatment plans simply to take advantage of systemic bias in the system. This double standard erodes trust and pushes compassionate professionals out of the system, leaving patients with fewer options for quality care.

The confrontational nature of the current framework, where adjusters are now termed "litigation specialists," creates barriers rather than solutions. Patients unable to navigate this complex system without legal representation are left stranded, especially if they can't access a lawyer. (many claimants are unable to access a lawyer following a denial if at fault since the placement in the MIG means a case has no legal value in these situations the consumer will linger out of treatment until issues become chronic then they will likely be out of MIG or Catastrophic).

Meanwhile, the FSRA appears more focused on perception-based studies than on addressing the real issues reported by healthcare providers. This disconnect leads to deteriorating patient outcomes, with individuals developing chronic conditions that are far more costly and challenging to treat.

We urgently need to shift back to a patient-centered approach that emphasizes fairness and efficiency within a self-regulated framework. Simplifying treatment processes and streamlining dispute resolution will reduce costs and restore faith in the system. Protectionist policies and bureaucratic gatekeeping have not served us well over the past 25 years. It's time to listen to healthcare professionals and prioritize the well-being of consumers, ensuring that accident victims receive the timely and compassionate care they deserve.

Creating Proactive Legal Risk Mitigation Strategies

Instead of denying claims and pushing the treatment costs onto the public system, which later come back into the accident benefit system, insurance companies must focus on longer-term injury mitigation strategies. This includes proper assessment of injuries, early intervention, a simpler solution of treatment plan reviews, and deference to the clinical expertise of their comprehensive rehabilitation programs. It's not only about avoiding future liabilities but also about ensuring patient's recovery and well-being, if a person is able to live with an ongoing maintenance program why would there be a need to settle.

Investing in Early Intervention and Rehabilitation

Government recognizes the value of investing in early intervention within other frameworks, such as primary care, yet the auto insurance framework does not put that forward. Proper rehabilitation requires properly funding rehabilitation. This strategy will ultimately reduce the costs associated with disputes, chronic pain management, and disability claims.

"Proper rehabilitation requires properly funding rehabilitation"

Observations:

The displacement of legal risk mitigation and rehabilitation costs to other systems is a lose-lose situation for all parties involved. The actual cost of such practices is borne not just by the insurance companies but also by the public health system and society. Insurance companies can create a more sustainable, ethical, and cost-effective system by focusing on the lessons learnt from past experiences and promoting a treatment-based approach. This will reduce the financial burdens on the public system and ensure better health outcomes for accident victims.

The Boomerang Scenario and the Psychology of Denied Claims

A vital aspect of this discussion is the psychological impact on individuals whose claims are denied prematurely. When an insurance framework prematurely states a person is not injured, it does not eliminate the person's presence from the system. It often exacerbates the situation, especially when these denials occur early in the claim's life.

Individuals denied early on in the process do not get a chance to adjust to the ongoing nature of their pains psychologically or, if applicable, the permanence of their injuries. This can lead to an amplification of their pain responses due to the frustration of feeling

diminished and their injuries devalued. The result can be a stronger desire to challenge or 'punish' the system or framework they perceive as having failed them.

The Importance of Acknowledgment and Validation

It is crucial to remember that while not all patients fully recover from their injuries, that doesn't mean they can't lead productive lives. Many individuals live with disabilities due to medical and unfortunate circumstances through no fault of their own, or as a result of accidents, yet manage to adapt to their changed physical abilities and continue to be productive members of society.

When injured people are denied or dismissed too early, they often invest their energy fighting in validating their cause, looking backward to justify their inability to return to their pre-injury life. This constant looking back at their cause of injury prevents them from finding a 'new normal' that can satisfy them and allow them to reintegrate into society.

The Need for a Compassionate and Fair System

Not all minor injuries recover, and not all serious injuries are permanent. Adherence to fixed ideas about what a recovery looks like is a very expensive strategy and a losing proposition.

Ultimately, not everyone recovers from injuries sustained in accidents, but everyone should feel that the system did not diminish them. It is an undeniable fact that insurance frameworks need to balance financial sustainability with the delivery of benefits to the auto insurance consumer. This can only be done by taking advantage of existing self-regulating frameworks and not trying to rig the system with very complicated and expensive preferred provider networks of any kind or adhering to strict definitions and frameworks that have become outdated.

When people feel dismissed or invalidated by these systems, it results in a boomerang effect, where the denied individuals return, bearing additional psychological burdens and carrying higher costs for both the auto insurer and society at large.

Thus, it is paramount for insurance treatment systems to ensure that claims are assessed fairly and accurately, that individuals are provided with the care and support they need, and if they are unable to recover further a maintenance program that is typically much less expensive than a dispute process is provided to enable them to continue working. Doing so not only reduces the overall costs to the system in the long run but also promotes a healthier, more sustainable society where individuals, regardless of their level of injury recovery, can find their 'new normal' and continue to be productive members.

Attendant Care Consultation Section:

The failure to update fee schedules and attendant care guidelines over the past decade reflects an approach that rarely works, the hope that the problem would simply resolve itself. This neglect has primarily benefited two groups: lawyers and insurance companies. Lawyers secure large settlements, while insurance companies pass claim costs onto consumers the following year with a markup, profiting from these inefficiencies in the system. Meanwhile, the patients—the very people the system is supposed to protect—are left without the care and support they need, ultimately driving up long-term costs for everyone involved. It's high time we address these issues head-on and ensure fair, inflation-adjusted compensation that reflects the realities of care provision in Ontario.

Ontario Attendant Care Benefits:

Attendant care is fundamental for individuals with serious injuries, including traumatic brain injuries, spinal cord injuries, significant orthopedic trauma, and amputations. This level of care allows Personal Support Workers (PSWs) to assist with critical daily activities such as personal care, safety monitoring, meal preparation, hygiene, and therapeutic interventions.

Initially, the Form 1 assessment was designed to determine the financial amount that an injured person could allocate toward hiring a PSW. The Financial Services Commission of Ontario (FSCO) published a bulletin in 2018 regarding the calculation of these benefits:

The revised Attendant Care Hourly Rate Guideline mandates the use of specific hourly rates with the Form 1 assessment to calculate the monthly attendant care benefit in compliance with section 19 (2) of the Statutory Accident Benefits Schedule (SABS), effective September 1, 2010.

The more recent Malitskiy v. Unica case has resulted in insurers applying outdated rates, leading to partial payments that fall far below what is necessary. Claimants are being left to cover the balance, which many simply cannot afford. This practice effectively denies them access to the care they require, offloading costs onto publicly funded providers. Some patients are getting attendant care but it's though publicly funded services.

Yet despite public sector providers, numerous individuals with severe injuries have been left without the critical services they need to manage their day-to-day lives.

The Costs of running a profitable operations scheduling and Providing Attendant Care means remuneration is $55-$60. These companies employ people take and all healthcare companies deserve to make a profit.

The cost of delivering attendant care services has risen significantly, especially following the COVID-19 pandemic. Ontario is currently experiencing a shortage of PSWs, leading employers and agencies to increase wages to attract and retain staff. Furthermore, the provincial government has implemented a $3 per hour wage increase for PSWs in the public sector, which has driven up wages in the private sector as well.

When employing a PSW at $25 per hour, employers also face additional costs such as:

- Canada Pension Plan (CPP): $1.49
- Employment Insurance (EI): $0.57
- Workplace Safety and Insurance Board (WSIB): $0.42

This brings the total cost to approximately $27.48 per hour. Additional operational costs include insurance premiums, recruitment, administrative overhead, and staff turnover.

The impact of inflation, future pandemics, and unforeseen circumstances will only drive these costs higher, highlighting the need for adjustments in the compensation structure for these services.

Addressing the Form 1 Process and Attendant Care Rates

A significant issue arose when healthcare professionals like physiotherapists and chiropractors were restricted from completing the Form 1. This short-sighted attempt to limit attendant care utilization failed, as it merely shifted the demand to nurses and occupational therapists, resulting in increased costs to the system. The need for attendant care persisted, but now patients had to seek out additional healthcare professionals, adding unnecessary expense and complexity. This approach contradicts the principles of LEAN management and efficient, patient-centred care.

This decision was made without sufficient consultation with healthcare professionals and has made access to the Form 1 both more expensive and more challenging for patients. Restricting completion of the form to only occupational therapists and nurses has unnecessarily limited access to essential services while driving up public healthcare costs.

Restoring the ability of physiotherapists and chiropractors to complete the Form 1 would improve access to care by utilizing their expertise to assess and diagnose the need for attendant care, making the system more efficient and cost-effective.

Solutions:

1. Update Form 1 Rates: Rates need to be adjusted to reflect the current market environment, factoring in inflation and other cost increases.

2. Allow Competitive Billing: Providers should be allowed to bill for approved services based on the total minutes of care provided, using their own rates. This method encourages competition and allows claimants to choose the best providers.

3. Expand Authorized Professionals: Restoring the ability of physiotherapists and chiropractors to complete the Form 1 will increase access to this essential service without additional costs, enhancing patient outcomes. There was no rationale for removing providers from completing this form in the past and it has harmed access to care.

4. Raise Cap Rates: The maximum monthly amounts for non-catastrophic and catastrophic injuries need to be increased from the current $3,000 and $6,000 respectively to better reflect the actual costs of providing care.

These steps will ensure that injured Ontarians can access the essential services they deserve through the insurance benefits they have paid for.

A New Proposed Attendant Care Rate $55-$60

We advocate for an updated hourly rate of $55-$60 for attendant care services, based on the following justifications:

1. Wages and Employment Costs: The true employer cost of hiring a PSW at $25 per hour rises to around $33 per hour when considering employer contributions.

2. Business Overhead: Additional operational costs, including insurance, recruitment, administration, and training, add another 35-40% to the base cost, bringing the total hourly expense to about $45.

3. Sustainable Profit Margins: A profit margin of 20-25% is necessary for reinvestment, quality improvements, and attracting top talent. This brings the hourly rate to the proposed $55-$60 range.

This rate aligns with other service sectors in Canada and is essential to maintaining high-quality attendant care while ensuring the sustainability of the businesses providing these critical services.

An hourly rate of $55-$60 is not only in line with current market conditions but is necessary to cover all the costs associated with providing quality care. Implementing these changes will help ensure that seriously injured individuals in Ontario receive the care they need, funded by the insurance benefits they have already paid for.

Rationale for Form One Creation Reinstatement for Physiotherapists and Chiropractors:

A leaner more efficient system is required and reinstatement of the creation of the Form One for physiotherapists and chiropractors is a must that saves money and costs nothing.

The financial services sector must adopt a more integrated approach when making decisions that affect consumers, healthcare professionals and, by extension, patients. The removal of physiotherapists and chiropractors from completing Form 1 assessments is a prime example of the unintended consequences that arise from siloed decision-making, which focuses solely on auto insurance rates without considering the broader healthcare landscape. The unintended consequence was higher claim costs and increased utilization of occupational therapists on files where they would not have been involved. Introducing a new healthcare provider into a claim is expensive, especially when the services then require ongoing supervision of form ones for patients already being seen by physiotherapists and chiropractors.

Physiotherapists, who often visit patients in their homes, were ideally positioned to perform these assessments, ensuring timely access to care. However, by restricting this responsibility to nurses and occupational therapists, access to essential assessments was significantly reduced, creating additional strain on an already overburdened system. This decision increased demand for nurses in the auto insurance framework, drawing them away from critical roles in hospitals and other healthcare settings, further exacerbating staffing shortages.

Healthcare systems—whether government-funded, private, or tied to auto insurance—do not operate in isolation. Decisions that affect one area have ripple effects throughout the entire system. Failing to account for this interplay compromises consumer access, drives up costs, and delays recovery. It is essential that decisions impacting healthcare professionals take into account the broader healthcare delivery frameworks, ensuring alignment with the realities of patient care in Ontario.

Reinstating the ability of physiotherapists and chiropractors to complete Form 1 assessments would streamline access to care, reduce costs, and alleviate pressure on other parts of the healthcare system. In order to serve the public effectively, regulators must consider the full scope of their decisions and prioritize patient-centred care by leveraging all available healthcare resources efficiently.

Today more than half of Ontario's accident benefits costs now occur outside of clinics, driven by skyrocketing occupational therapy expenses due to their required involvement in Form 1 assessments. Fifteen years ago, OTs were rarely involved in cases, but now their mandatory role creates a recurring expense. Each time the Financial Services tries to cut

costs by manipulating care in some way, it inadvertently introduces new cost drivers that multiply expenses instead.

SABS Section Recommendations Summary

1. HSP Licensing

- Remove redundant HSP licensing requirements for clinics owned by regulated healthcare professionals to reduce administrative burden and costs.
- Shift FSRA's focus on clinics not governed by regulated healthcare professionals to ensure better oversight and resource allocation.
- Introduce a two-year moratorium on new entrants into the HSP and HCAI systems, except for clinics regulated by healthcare colleges once any fee increases are implemented.

2. PSG – Increase to 400 dollars per 50 minutes

- Index PSG rates to a healthcare-specific inflation index rather than the general CPI to reflect true cost increases in healthcare delivery.
- Implement immediate adjustments to the PSG rates rather than staggered increments due to long-standing under-compensation.
- Consider compensating healthcare providers for charting, phone calls initiated by adjusters, and additional paperwork like progress notes.
- Include compensation for professional obligations like charting as part of the treatment time.

3. MIG –$15000.00 total cap with first 12 weeks at $9430.00

- Increase rates in the Minor Injury Guidelines (MIG) framework, which have been stagnant for 15 years, to prevent further exodus of healthcare providers and poor patient outcomes.
- Remove unnecessary layers of bureaucracy, as they add to healthcare delivery costs without improving patient outcomes. Remove the 12-week block framework altogether.

4. Attendant Care – Increase to 55- 60 dollars per hour

- Address the systemic undervaluation of female-dominated professions like physiotherapy, occupational therapy, and speech therapy in the attendant care framework. Pay rates should reflect the importance and complexity of the work.
- Align fees more equitably between physiotherapists and chiropractors, correcting gender equity disparities.

5. Dispute Resolution

- Implement a fair dispute resolution process involving randomized second and third opinions from healthcare professionals of the same discipline, ensuring transparency and impartiality that is cheaper, less prone to dispute and faster. – FairCARE

- Remove for the early stage (first two years) treatment disputes from the License Appeal Tribunal (LAT) system to prevent long delays in decisions on care, doing so will increase speed and access to care and decrease all auto insurance framework costs. Patients should not have to wait years for necessary treatment decisions.

- Consider returning all dispute resolution to the healthcare framework for quicker and more efficient resolutions if possible.

- Use the regulated healthcare framework for second opinions and third opinions rather than relying on costly, redundant insurance assessments that create delays.

- Focus on achieving fair, objective outcomes rather than litigation-driven assessments by PPNs.

6. Create a HSP ETHICS Committee where Healthcare Professionals can escalate Ethical Concerns about Insurer Behaviour to FSRA

- The ethical regulated healthcare framework should be the default framework for all health service providers and auto insurers as it pertains to care and care programs.

-FSRA should adopt the regulated healthcare framework as the default framework for all health service providers requires collaboration and oversight from a Healthcare Professional Committee to oversee auto insurance and treatment provider behaviour. It's the step beyond principles-based regulation.

7.Ensure Insurer Penalties are not passed onto consumers

- FSRA must ensure that the fines and penalties imposed on insurance companies by regulators, government agencies and judges for bad faith are not passed on to consumers. These should be listed within reserves in financial statements to ensure they are not integrated within premiums.

8. Eliminate Preferred Provider Networks (PPNs)

- Eliminate closed or open Preferred Provider Networks (PPNs), which produce biased results due to care being client centred rather than patient centred as well as asking for improper financial incentives. Instead, focus on transparency and fairness through randomized assessments and ensuring quality and patient centered care is the focus of the treatment framework not referrals from insurance companies.

9. Reinstate the Form One to Be Done by Physiotherapists and Chiropractors

- There should be reconsideration of the limitations imposed on physiotherapists and chiropractors in completing certain forms (such as Form One), as these professionals are often best equipped to assess functional needs due to their close interaction with patients, this will increase treatment access and decrease costs without requiring introducing additional healthcare professionals simply to fill out a form.

Recognizing that when frameworks limit the authority of healthcare professionals to convey a diagnosis or opine on issues within their education level and professional scope the auto insurance consumer suffers since it manipulates the market and what can be easily provided by a physiotherapist must now be provided by multiple healthcare professionals.

Today more than half of Ontario's accident benefits costs now occur outside of clinics, driven by skyrocketing occupational therapy expenses due to their required involvement in Form 1 assessments. Fifteen years ago, OTs were rarely involved in cases, but now their mandatory role creates a recurring expense.

Each time the Financial Services tries to cut costs by manipulating care in some way, it inadvertently introduces new cost drivers that multiply expenses instead.

10. Refocus the FSRA Key Performance Indicator from short term auto premium fee suppression to long term auto insurance framework sustainability

- FSRA's key performance indicator (KPI) of maintaining low auto insurance rates has come at the expense of patient recovery, auto treatment sustainability. As detailed in this section FSRA should shift its focus from cost containment to ensuring efficiency of the system and stakeholders especially insurer frameworks, disputer resolutions, software systems, regulatory efficiency, patient outcomes and overall long-term system efficiency.

These recommendations collectively emphasize the need for reform in HSP licensing, proper compensation, dispute resolution processes, gender equity in healthcare professions, and a focus on patient care over cost-containment measures.

11. Align Physiotherapists' Scope of Practice Under SABS with other Frameworks:

- Amend the Statutory Accident Benefits Schedule (SABS) to recognize existing ability of physiotherapists to make a diagnosis and communicate diagnoses made by other healthcare professionals to insurers. This change would eliminate inefficiencies and reduce the need for multiple healthcare providers to handle tasks that a physiotherapist can manage effectively. The need for a "medical opinion" to approve treatment recommendations does not occur in OHIP, WSIB, or Private practice. Physiotherapists are primary care providers and ignoring this simply results in higher costs downstream and harms access to care.

- Reducing disputes by recognizing a physiotherapists' authority allow physiotherapists to provide diagnoses and documentation already within their scope of practice to prevent unnecessary delays and costs. This would decrease delays in patient care and reduce the need for Independent Medical Examinations (IMEs), streamlining the treatment process reducing costs.

12. Improve Adjuster Training and Standardize Information:

- Implement standardized FAQs and training for insurance adjusters on the education and scope of practice of physiotherapists to reduce inefficiencies. Given the high turnover rate of adjusters (3-5 years), this would help mitigate delays caused by adjusters unfamiliar with physiotherapy practice, improving overall efficiency. Adjuster also need standardized understanding of treatment frameworks like the MIG and PSG since despite over a decade of being unchanged healthcare providers are dealing with insurance adjusters on basic issues of understanding. Improving the education and standardizing training of adjuster will prevent cowboy behaviour and prevent unnecessary disputes that result in cost increases.

13. Implement a Code of Conduct and Oversight Mechanism for Insurance Adjusters

FSRA should develop and enforce a mandatory **Code of Conduct** for insurance adjusters specifically addressing their interactions with healthcare professionals. This code should set clear standards of behaviour, including limits on administrative requests, timelines for responses, and protocols for ethical conduct. Alongside this, FSRA should create a dedicated oversight team and mechanism to monitor adjuster compliance, investigate complaints from healthcare providers, and penalize any abuses of process or unfair administrative behaviours. This would ensure accountability, protect healthcare providers from administrative burdens, and ultimately safeguard consumers by improving access to timely care.

FSRA's Statutory Obligations Under Section 3(2) of the FSRA Act

The Financial Services Regulatory Authority of Ontario (FSRA) is guided by its statutory objects under section 3(2) of the FSRA Act, 2016 (the "FSRA Act").

The following statutory objectives set out in section 3(2) of the FSRA Act, 2016 (the "FSRA Act"):

- to regulate and generally supervise the regulated sectors,
- contribute to public confidence in the regulated sectors,
- monitor and evaluate developments and trends,
- promote transparency and disclosure,
- deter deceptive or fraudulent practices,
- promote high standards of business conduct,
- protect consumer rights, and foster a strong, sustainable, competitive, and innovative financial services sector.

FSRA is falling short in the following ways with respect to their legislative objects as per section 3(2) of the FSRA Act:

1. Regulate and generally supervise the regulated sectors:
 - HSP Licensing: FSRA is applying redundant and burdensome licensing requirements on clinics owned by regulated healthcare professionals, which adds unnecessary costs and complexity without improving patient care or oversight. The focus should be on unregulated clinics, not those governed by professional healthcare bodies.

2. Contribute to public confidence in the regulated sectors:
 - Dispute Resolution: The long delays and litigation-driven processes within the LAT system undermine confidence in the regulatory framework. Patients are left waiting for necessary treatments, damaging public trust in the fairness and efficiency of the system. An alternative, like the FAirCARE system, would offer faster, more transparent resolutions.

3. Monitor and evaluate developments and trends in the regulated sectors:
 - Rate Increases (PSG, MIG, Attendant Care): FSRA has failed to adjust compensation rates in accordance with healthcare inflation trends. By maintaining outdated rates in the face of rising costs, FSRA has allowed a misalignment between healthcare providers' needs and the regulatory framework, contributing to the exit of professionals and declining patient outcomes.

4. Promote transparency and disclosure of information by the regulated sectors:

- Preferred Provider Networks (PPNs): The use of PPNs introduces biases into care provision, driven by financial incentives rather than patient-centred treatment. This lack of transparency in how providers are selected and incentivized erodes trust in the fairness of the system.
- Ethics Committee: FSRA lacks a clear pathway for healthcare professionals to raise and address ethical concerns regarding care delivery within the auto insurance system. Without transparency in handling such concerns, public confidence suffers.

5. Deter deceptive or fraudulent conduct, practices and activities by the regulated sectors:
   - Insurer Penalties: FSRA needs to ensure that fines and penalties imposed on insurers for bad faith or unethical practices are not passed on to consumers through increased premiums. By not enforcing this, consumers face higher costs without knowing the true source of the increase.

6. Promote high standards of business conduct:
   - Adjuster Training: The inconsistent and often inadequate understanding of healthcare frameworks (like the MIG and PSG) among adjusters, coupled with high turnover, leads to inefficiencies and improper handling of claims. This can result in "cowboy behaviour," creating unnecessary disputes and undermining the professional conduct expected in the sector.

7. Protect the rights and interests of consumers:
   - Dispute Resolution: Consumers are disadvantaged by the current LAT system, which often results in long delays before care decisions are made. The inefficiency of this system does not adequately protect consumers' rights to timely treatment and proper care, violating the spirit of consumer protection.

8. Foster strong, sustainable, competitive and innovative financial services sectors:
   - Focus on Long-term Sustainability: FSRA's current KPI, focusing on short-term auto insurance premium suppression, has come at the expense of long-term sustainability. By failing to prioritize system efficiency, patient outcomes, and regulatory improvements, FSRA has neglected its duty to ensure the long-term health of the auto insurance and healthcare delivery frameworks.
   - Preferred Provider Networks: PPNs reduce competition in the marketplace by restricting which providers can deliver care, which hampers innovation and reduces the incentive for clinics to improve care delivery and efficiency. A fair and open system that values quality over financial incentives is crucial for a sustainable sector.

My recommendations address these gaps by advocating for reforms that reduce unnecessary bureaucracy, improve transparency, promote ethical standards, and ensure that consumer rights and patient care are prioritized over short-term cost containment.

SECTION 3:

A response to the Health Claims for Auto Insurance (HCAI) System Review

A bad system will beat a good person every time

W. Edwards Deming

October 2024

Foreword

The Financial Services sector is currently entangled in a cycle of duplicating existing, efficient systems, mistakenly believing that passing these redundant costs onto auto insurance consumers is justifiable. This strategy not only fails to deliver improved outcomes but also unnecessarily inflates expenses. It is imperative that we reassess this approach and explore alternative methods to obtain the necessary data without perpetuating inefficiencies. Since its inception in the late 2000s, the Health Claims for Auto Insurance (HCAI) system has experienced intermittent progress, marked by starts and stops rather than meaningful innovation.

This misguided approach squanders valuable resources and drives up costs, particularly in the auto insurance industry where the primary goals should be enhancing care quality and reducing expenses. Professional healthcare regulation already encompasses both healthcare professionals and clinics, rendering the creation of a separate licensing framework for regulated healthcare providers superfluous and financially burdensome. Our healthcare colleges possess robust self-regulation models that facilitate unbiased second and third opinions. Introducing additional layers, such as closed preferred provider networks, merely increases costs without delivering any tangible improvement in care quality.

The decision to develop the HCAI system, despite the availability of more reliable and efficient platforms like the Telus portal used by the Workplace Safety and Insurance Board (WSIB), was a strategic error. Rather than complicating the landscape with new billing and invoicing systems, we should leverage proven, effective platforms. The solution lies in transcending the narrow confines of financial services and adopting systems that have already demonstrated their efficacy. This relentless reinvention of the wheel is a significant factor contributing to the persistently high costs of auto insurance. By introducing new systems that offer minimal added value, we divert critical resources away from direct patient care. It is time to prioritize what works and eliminate the creation of additional inefficiencies.

This same flawed mindset that led to the allocation of one billion dollars to eHealth is now driving the unnecessary reinvention within our auto insurance system. Instead of developing new systems that add complexity and cost, our focus should be on utilizing existing, efficient solutions. We cannot afford to repeat past mistakes; it is crucial to prioritize effective strategies, streamline processes, and ensure that resources are directed toward improving patient care rather than creating more bureaucratic obstacles. The more we squander money on redundant systems, the more consumers bear the financial burden.

As the saying goes, “When you’re going down the wrong road, turn back.” By embracing proven platforms and fostering collaboration between regulators and healthcare providers,

we can redirect our efforts towards creating a more efficient and sustainable auto insurance claims system. This will not only reduce administrative burdens and lower costs but also enhance the quality of care for patients, ultimately benefiting all stakeholders involved.

Trapped in the Past: Why the Outdated HCAI System is Failing Healthcare Providers and Patients

A Detailed Commentary on the HCAI System

Foreword:

It's concerning that Financial Services, in an effort to protect the public and ensure all stakeholders benefit from the HCAI system, never reached out to the healthcare providers who use the system daily—until the Ministry of Finance prompted them to do so in a recent budget. This glaring omission in stakeholder engagement highlights a fundamental disconnect between the regulators and the professionals tasked with delivering care. While the system was developed with input from insurers, the voices of those who actually rely on the platform to manage claims and facilitate patient care were ignored for years. This oversight not only undermines the efficiency of the system but also impacts the quality of care provided to consumers, who ultimately suffer from the delays and administrative bottlenecks created by an inefficient platform. By failing to include healthcare providers in the conversation, Financial Services has overlooked a key element in protecting the public—ensuring that the tools used to support patient care are effective and user-friendly.

Healthcare professionals have no issue with the Insurance Bureau of Canada (IBC) being involved in the development of the HCAI system. After all, insurance companies are key stakeholders in the claims process. However, the glaring question remains: where was the Financial Services Regulatory Authority (FSRA) in ensuring that the actual users of the system—healthcare providers—had meaningful input? FSRA, as a regulator that is supposed to protect consumers and balance the interests of all parties, failed to consider the perspectives of the very professionals who use the system daily to support patient care.

By neglecting to include healthcare professionals in the design and implementation of HCAI, FSRA missed a critical opportunity to create a system that not only serves insurers but also functions efficiently for those who are directly responsible for patient outcomes. Instead of a collaborative approach that might have resulted in a well-rounded, user-friendly platform, FSRA has allowed the creation of a system that burdens healthcare providers with administrative inefficiencies. This oversight does not protect consumers; in fact, it harms them by drawing healthcare professionals' time and focus away from patient care and into an endless cycle of paperwork.

This is a clear historical failure of impartial regulatory responsibility. FSRA's role is to ensure that all systems serve the broader public interest, and in this case, they failed to protect both consumers and healthcare professionals. Without a system that facilitates quick and efficient claims processing, patient care is delayed, creating a ripple effect that ultimately

impacts the quality of care and the speed at which consumers can receive the benefits to which they are entitled.

Imagine navigating with a decade-old smartphone—its screen cracked, apps sluggish, and software outdated. You tap the screen, waiting impatiently as it lags behind your commands, unable to run the latest applications that could make your life easier. It isn't until you handle a new, state-of-the-art device that you realize how much you've been missing: lightning-fast responses, intuitive interfaces, and seamless integration with the world around you. This stark difference encapsulates the experience of healthcare professionals contending with the antiquated Health Claims for Auto Insurance (HCAI) system. Despite relentless efforts and countless suggestions for improvement, the platform remains frozen in time, a relic overshadowed by modern solutions available today. While other systems evolve and adapt to user needs, HCAI lags, burdening providers with inefficiencies that impede their ability to deliver optimal care. The disparity highlights the system's inadequacies and underscores the pressing need for transformative change.

Meanwhile, suggestions from insurers are handled expeditiously—most likely due to the access insurers and organizations like the Insurance Bureau of Canada (IBC) have within HCAI and FSRA, as noted in a 2012 article in Canadian Underwriter. For instance, when insurers reported difficulties reconciling health care invoices, the Financial Services Commission of Ontario (FSCO) swiftly released new guidelines making certain fields mandatory to accommodate their needs. This rapid response highlights a glaring disparity: while insurance companies seem to have a direct line for implementing changes, healthcare providers are left navigating an antiquated platform with no avenue for enhancement—a situation that underscores the urgent need for reform. The addition of mandatory fields to streamline insurance company use is contrasted with requests for mandatory fields from healthcare professionals, like the invoice signature section, which falls flat.

The Current State of invoicing for Accident Victims with HCAI

Here are the five steps to submit ONE invoice to an auto-insurer: This Process can take will take several months. And they do not include the follow up calls and time for multiple touchpoints with insurer and at all parts of the process.

The Premise:

The following is a typical Auto Insurance Invoice process for a patient receiving treatment within Block 2 of the minor injury framework's a very common category.

It is an example of a sample person involved in a car accident with auto insurance and two work plans one through his employment and one through a spouse.

To ensure simplicity we assume both plans cover 80% per session and the attends eight treatment dates in one month.

Treatment remuneration for block 2 (one month of treatment) of the minor injury guideline is 500 dollars.

Each session is therefore valued at $62.50, which is the maximum the auto insurer will pay for block two divided by the eight sessions during this period of the minor injury guideline. ($62.50 is significantly below the market rate)

500/8= 62.50 per session

Auto Insurance Invoicing steps:

Step One: Repeatedly filing the Claim with the Patient's own Work Insurance (30 days)

(The expected turnaround time for this step is between 30 to 60 days. While the submission can typically be completed electronically, in many cases, a manual submission may be necessary.

In instances where payments are made directly to the patient, they are responsible for forwarding the amount to the healthcare provider along with the statement of benefits. It's often necessary to remind patients to forward these payments and statements, as this step is crucial for the completion of the claim process.)

Also, if the work insurance requires a physician referral the process cannot begin until the patient obtains one. This means care can be delayed.

A. Electronic Submission (If Possible): We attempt to file the claim electronically with the patient's primary work insurance typically TELUS to receive direct payment for 80% of each treatment session. With each session valued at $62.50, the insurance would reimburse $50.00 per session (80% of $62.50 = $50.00).

  - Mathematically, for each session: (80% of $62.50 = $50.00)

B. Patient's Role: The patient must sign and confirm all forms submitted. In cases where payments are made directly to the patient, they are expected to forward the amount to us along with the statement of benefits. We often need to remind the patient to do this.

C. Repeating the Process: If electronic submission is permitted, this process is replicated for each of the eight treatment sessions over the course of the month.

  - Total payment expected from the first insurer for all sessions: (8 times $50.00 = $400.00)

D. Manual Submission (If required): If electronic submission is not possible, we then must complete and mail physical claim forms to the first insurer after all eight sessions have been attended by the patient, to receive the same 80% coverage for each session.

  - This involves collecting all documentation and manually calculating the reimbursement for the entire block of treatment sessions (8 sessions × $50.00 per session = $400.00 total expected from the first work insurer).

This initial step already involves a mix of administrative tasks that must be performed accurately to ensure proper payment from the work insurance. The process can be lengthy and must be handled with precision to avoid delays or errors in reimbursement.

Step Two: Filing the Claim with the Patient's Spouse's Work Insurance (30-60 days)

Steps: Filing the Claim with the Patient's Spouse Work Insurance

Additional time may be added to the process due to the need for obtaining statements from patients. Patients receive statements and payments in various formats, including checks, e-transfers, and direct mail. Sometimes, the payment is directly deposited, and a statement is sent by mail or email.

The patient is required to sign and confirm all forms that are submitted.

- Handling of Payments: In instances where payments are made directly to the patient, they are responsible for forwarding the amount to the healthcare provider along with the statement of benefits. Yet it's often necessary to remind patients to forward these payments and statements, as this step is crucial for the completion of the claim process.

After receiving payment and statement details from the person's first insurance, we must mail a submission to the second insurer for 80% of 12.50 per session to get $10.00. Patient needs to sign and confirm all forms.

A second work benefits insurer will not accept an electronic submission.

<u>Step Three: Preparation and confirmation of Documents</u> (thirty minutes to an hour)

After receiving both sets of partial payments and all statement details from the person's second insurance, (if anything is missing the invoice will be denied by the auto insurer) we gather all the proper documentation that both work plans have paid for their respective portions of each session.

We deduct what we received from both work plans from what we would receive for Block 2 from the auto insurer, which is 500.00 dollars.

500 – ((8x50)+(8x10.00))= 480.00
Value of services for block 2 = 500 dollars
Monies received from first work insurer = 400 dollars
Monies received from second insurer = 80.0 dollars

Total received from the person's work insurance 480.00

<u>Step 4: Electronic submission through HCAI</u> (15 – 20 minutes)

We then submit a 7-page invoice to the auto insurer for $20.00.

For a patient in Block 2 of the MIG it's a particular invoice called an OCF-21 C, and here is a link to the instruction manual if you are interested.

https://hcaiinfo.ca/Health_Care_Facility_Provider/documents/manuals/OCFs/OCF-21C%20from%20plan%20web.pdf

Twenty dollars, is the difference of 500 dollars minus 480.00. We submit this invoice electronically through a proprietary auto insurance invoicing system called HCAI, which cannot accept any of the required statement attachments.

Of Importance: The existence of different types of invoices, such as OCF-21B and OCF-21C, within Ontario's automobile insurance system represents a bureaucratic quagmire that significantly complicates the billing process. This complexity is not just due to having multiple invoice formats, but also because these formats are nuanced and cater to slightly different purposes, making it challenging to determine the appropriate form for specific services.

For instance, the OCF-21B is used for invoicing medical and rehabilitation goods and services, assessments, and examinations submitted under the OCF-18, while the OCF-21C specifically caters to services delivered under the Minor Injury Guideline for accidents occurring on or after September 1, 2010. Each form has several detailed sections, such as Claim Identifier, Applicant Information, Payee Information, and specific codes for injuries and services rendered. This level of detail, which is unnecessary, adds layers of complexity to the invoicing process.

The differentiation becomes particularly problematic when services overlap categories covered by both forms. In such cases, providers may find themselves navigating a labyrinth of bureaucratic procedures to ensure proper billing, a task that is both time-consuming and prone to errors. This scenario begs the question: why, after over a decade, has the system not been streamlined? The Health Claims for Auto Insurance (HCAI) system, despite its intentions to facilitate and standardize billing practices, falls short in terms of user-friendliness and efficiency.

This situation is peculiar to Ontario's auto insurance framework and is not observed in other insurance or healthcare billing systems. The convoluted nature of these invoicing requirements seems to be an outlier rather than a standard, raising concerns about its practicality and the burden it places on healthcare providers and insurance adjusters alike. The need for simplification and rationalization of this process is evident, as it would not only ease the administrative burden but also potentially improve the overall efficiency of the healthcare and insurance systems.

Here is the OCF-21B user manual 30 pages.

https://www.hcaiinfo.ca/Health-Care-Facility/documents/OCFs/OCF-21B.pdf

Step 5: Faxing the work benefits statements to the auto insurance adjuster (5-10 minutes)

To complete invoicing, we must fax or email the five statements from the person's first work benefit plan to prove how much we received to the adjuster, who may or may not have changed by now. These statements can not be attached to the electronic HCAI invoice and must be sent separately.

And

We must fax or email the five additional statements from each visit's second work benefits plan.

(We are often asked to keep them separate because it can be confusing.)

If any statements are missed or delayed due to administrative issues at the work insurance carrier, we must call the work plans and follow up, which is also time-consuming further delaying payment.

In the end, the administrative hurdles for submitting an invoice for auto insurance are endured to help the patient because if the clinic doesn't, the patient will not have any access to ongoing treatment benefits, and we will be unable to be reimbursed for subsequent invoices the next month.

Additionally, how we submit the invoices can vary due to the peculiarities of different work benefits plans which further complicates.

For non-MIG, non-Cat and CAT patients, the invoicing process still involves the same complex sequence of claims and adjustments between the patient's workplace benefits and the auto insurer.

In this current SABs invoicing system, it can take well over 90 days and multiple touchpoints to finally submit an invoice to the auto insurer. And this must be done for each monthly invoice. This process often goes well over six months to submit one invoice.

The HCAI System: A Red Tape Nightmare Hindering Efficient Healthcare Delivery

As a healthcare professional deeply invested in optimizing the efficiency of healthcare systems, I find the current iteration of the Health Claims for Auto Insurance (HCAI) system in Ontario to be profoundly troubling. The HCAI platform, intended to streamline the submission and management of health claims related to auto insurance, has instead become a labyrinth of inefficiencies and administrative burdens for healthcare professionals. This red tape nightmare not only hinders healthcare professionals from focusing on what truly matters—patient care—but also increases the risk of human error, delays payments, and necessitates significant time to correct avoidable mistakes. The human errors are then reported as compliance issues, which further frustrates healthcare professionals who already must spend considerable resources to ensure invoices are not delayed to ensure payment arrives in a timely manner, which is an already difficult process when we consider that work benefits statements must be applied and deducted from insurers submissions a process that can take upwards of seven months when multiple policies are present. (statistically, 50% of the time when a person has insurance and they are in a couple, they both have work benefits to apply and submit)

In contrast, organizations like the Workplace Safety and Insurance Board (WSIB) have recognized the pitfalls of systems like HCAI and have opted to use more efficient platforms such as the TELUS Health eClaims portal. The decision by WSIB underscores the pressing need for HCAI to reevaluate and overhaul its system to meet the demands of modern healthcare administration.

HCAI lags behind, burdening providers with inefficiencies that impede their ability to deliver optimal care. For instance, unlike the TELUS Health eClaims portal—which allows comprehensive memos to accompany invoices—the HCAI system limits the conveyance of crucial patient information. These memos in TELUS can highlight diagnostic results and exceptional issues, ensuring that essential details are front and center when invoices and treatment plans are reviewed. In contrast, HCAI's rigid coding system often strips away the nuanced descriptions clinicians provide. When a clinic uses a GAP code or ICD-10 code, the insurance adjuster does not see the descriptions the professional included; the code overwrites the clinician's description. This misalignment means that adjusters and clinicians aren't even looking at the same information—the clinician's intended approach is lost, and the adjuster's version is incomplete or manipulated. This fundamental disconnect devalues the portal altogether and underscores the pressing need for transformative change.

Despite HCAI being specifically built for "Health Claims," it falls flat as it cannot accept attachments, does not offer any specialized solutions to the communication problems in a system where rigorous timelines are required to be kept ensuring a patient has access to the necessary care to enable them to go back to work. As a clinician using the HCAI

system, it seems to have been created and never revisited. Much like the minor injury guideline and in that same spirit. Healthcare professionals are still waiting for the (five-year review of the MIG) promised 15 years ago. Much like the Ronco rotisserie chicken machine, HCAI's motto might be "Set it and forget it." There is no real-time software help from HCAI, there is no way to make suggestions, and the HCAI agency itself seems to be a black box of what I have heard is five employees that nobody has ever seen.

The Burden of Inefficient Systems on Healthcare Providers

Healthcare professionals are dedicated to providing the best possible care to their patients. However, when the administrative systems they rely on are fraught with inefficiencies, their ability to deliver patient care is significantly compromised. The HCAI system, with its complex forms, lack of user-friendly features, and inadequate communication channels, exemplifies this problem.

Since its inception in the early 2000s, the HCAI system has seen little to no improvement in enhancing the user interface for healthcare professionals. This lack of progress is alarming, especially when compared to advancements in other sectors and even within other agencies in the healthcare industry.

Complex and Redundant Forms: A Barrier to Efficiency

One of the most glaring issues with HCAI is the complexity and redundancy of its mandatory forms, such as the OCF-18 (Treatment and Assessment Plan) and OCF-21 (Invoice Form). These forms are not only lengthy but also require detailed information that often overlaps across different sections and forms. Healthcare providers are forced to input the same data multiple times, a process that is both time-consuming and prone to errors.

The user manuals for these forms are extensive, further highlighting the system's lack of intuitiveness. For busy healthcare professionals, wading through lengthy manuals is impractical and detracts from time that could be better spent on patient care. The intricate requirements and specific times certain invoice types must be used add another layer of complexity, increasing the likelihood of submission errors that delay payments.

Inadequate Communication and Feedback Mechanisms

Effective communication between insurers and healthcare providers is crucial for the timely processing of claims. Unfortunately, the HCAI system falls short in facilitating this communication. Insurers often provide generic or vague responses to submissions,

offering little insight into adjudication decisions. This lack of detailed feedback leaves providers in the dark, forcing them to guess the reasons behind claim denials or modifications and to resubmit forms without clear guidance.

This is a significant shortcoming for a single-use platform designed specifically for the healthcare industry. The inability to convey messages or attach supporting documents directly within the system is not only inefficient but also contributes to delays and increased administrative workload.

The Frustration of Mandatory Fields and Operational Red Tape

Adding to the frustration is the system's rigidity regarding mandatory fields. While HCAI addressed insurers' requests for additional mandatory fields to assist in reconciling invoices with treatment plans swiftly, healthcare providers' concerns about critical fields—such as the signature line—have been overlooked.

The requirement to navigate numerous mandatory fields hinders invoice submission, and when incomplete invoices are inadvertently submitted, payments are delayed, further straining provider resources.

It's infuriating that insurance companies' requests are prioritized, while healthcare providers' concerns about crucial issues are ignored, leaving us to struggle with delays and red tape!

The concerns I am expressing are due to the same spirit of disinterest that healthcare professionals have faced in the past. For example: Healthcare professionals for years voiced a long-standing problem where healthcare professionals repeatedly raised concerns about the invoicing rules. Specifically, they urged the regulatory body to change the rule from requiring invoices every 31 days to allowing monthly submissions. This inconsistency between invoicing cycles and calendar months caused significant operational challenges for clinics.

The rule was first introduced by the Financial Services Commission of Ontario (FSCO) in 2011 as part of an effort to reduce the high volume of paper submitted to insurers. According to the guidelines:

"The 2011 Guideline required that invoices be submitted only once a treatment plan has been completed, or once every 30 calendar days if the treatment extends beyond a month." (See Bulletin No. A-07/11 under the heading 'Frequency of Invoicing').

For years, healthcare professionals wrote to FSCO and the superintendent, requesting a change. The rule created an administrative burden because clinics could not submit invoices consistently at the beginning or end of the month. The 30-day interval often meant

that clinics were forced to shift their invoicing dates each month, leading to confusion and scheduling issues, especially in months with fewer than 30 days.

After years of conversations, FSCO finally amended the rule in December 2014. The updated guideline read:

"An OCF-21 submitted in respect of a Treatment and Assessment Plan (OCF-18) shall not be submitted until no further approved goods or services referred to in the OCF-18 will be rendered. However, where the delivery of goods or services referred to in an OCF-18 extends over 30 calendar days, the Service Provider may choose to submit an OCF-21 not more than once per calendar month." (See Bulletin No. A-12/14, or reference the OCF-21 Submission section in the Health Claims for Auto Insurance Superintendent's Guideline No. 04/14).

Although FSCO made the change, it took years of effort and suffering by healthcare professionals to get there. Unfortunately, the Financial Services Regulatory Authority of Ontario (FSRA), which replaced FSCO, has shown similar responsiveness to healthcare professionals' concerns. Despite the transition, the underlying issue remains healthcare professionals and the patients they serve are often ignored, leaving the burden of navigating these administrative hurdles squarely on clinics.

The Inability to Accept Attachments: A Critical Flaw

In today's digital age, the inability of the HCAI system to accept attachments is unacceptable. Supporting documents such as diagnostic reports, imaging results, and specialist evaluations are integral to substantiating treatment plans and claims. The current workaround—sending these documents separately via email or fax—fragments the workflow and increases the risk of miscommunication and lost documents.

This deficiency is glaring for an industry-specific platform. The inability to centralize all relevant information within a single system undermines the efficiency of the claims process and adds unnecessary administrative burdens on healthcare providers.

Comparing HCAI to the TELUS Health eClaims Portal

The TELUS Health eClaims portal serves as a stark contrast to the HCAI system. Used by organizations like WSIB, the TELUS portal offers a streamlined, user-friendly interface that simplifies the submission process; it isn't perfect either, but at least it's not as bad as HCAI with no support and no live customer support.

Moreover, the TELUS portal accepts detailed memos that can accompany submissions, enabling healthcare providers to include critical documentation within the same submission. This integration enhances communication with insurers and reduces the risk of errors or omissions by keeping things within the same platform. The platform's intuitive design minimizes the learning curve, allowing providers to focus on patient care rather than navigating complex administrative processes.

Other platforms can demonstrate that a more efficient, provider-friendly system is not only possible but already in use within the industry.

HCAI is not significantly better than sending a fax to healthcare professionals when we consider the number of off-platform conversations that are required.

The Call for Reform and FSRA's Role

In light of these issues, the Financial Services Regulatory Authority of Ontario (FSRA) must take decisive action to address the shortcomings of the HCAI system. Recently, FSRA announced plans to conduct reviews of various guidelines and systems, including the Health Claims for Auto Insurance system. This presents an opportunity to advocate for meaningful improvements.

However, FSRA must focus its resources effectively. Redirecting efforts toward areas lacking regulation—such as unregulated services like tow truck operators and body shops, which are fully involved in vehicle-related and accident matters yet currently operate without any oversight—could enhance fraud prevention efforts. FSRA could better utilize its resources by focusing on areas that professional colleges have historically neglected, ensuring a more comprehensive approach to regulation.

Recommendations for an Improved HCAI System

To transform HCAI into a platform that truly serves the needs of healthcare providers and patients, several key changes are necessary:

1. Simplify Forms and Processes: Streamlining forms to eliminate redundancy and unnecessary complexity will reduce the administrative burden. Implementing intuitive design features like autofill and real-time error checking can minimize mistakes and expedite submissions.

2. Enhance Communication Channels: Integrating a messaging system within HCAI would facilitate direct communication between providers and insurers. This feature would allow for quick clarifications, reducing delays caused by vague or generic feedback.

3. Allow Attachment of Supporting Documents: Enabling providers to attach relevant documentation directly within the system would centralize information, reduce the risk of miscommunication, and streamline the adjudication process.

4. Implement Real-Time Adjudication of customer service issues for healthcare professionals: Adopting real-time processing features similar to those in the TELUS portal would provide immediate feedback on issues, allowing providers to address issues promptly.

5. Provide Transparency in Adjudication Decisions: Offering detailed explanations for claim decisions within the platform would enhance understanding and allow providers to make necessary adjustments without unnecessary delays.

6. Automate Recurrent Claims: Introducing features that allow for the automation of recurring claims would significantly reduce the time spent on administrative tasks for ongoing treatments.

HCAI System Review Consultation Questions

1. Which initiative(s) should be prioritized? Why?

The initiatives that should be prioritized are Initiative B: Revising Forms and Initiative D: Other Initiatives. These align most closely with the core issues identified in the analysis of the current HCAI system, specifically regarding inefficiencies and administrative burdens faced by healthcare providers.

Initiative B, which focuses on revising forms, should be a top priority because the complexity, redundancy, and outdated nature of the forms are creating significant administrative hurdles. The current forms, such as OCF-18 and OCF-21, require repetitive data input, which increases the likelihood of submission errors and delays payments. Simplifying these forms, pre-populating fields, introducing mandatory digital signatures, and ensuring that they reflect the actual work effort of healthcare providers would directly alleviate the challenges you've outlined. By prioritizing form revision, the HCAI system could become more user-friendly, reducing the back-and-forth communication required to correct errors and allowing healthcare providers to focus on patient care rather than administrative tasks.

Additionally, Initiative D, which emphasizes improving the system's overall functionality and offering enhanced technical support, should also be prioritized. The lack of real-time technical support and communication within the HCAI system, which leads to delays, inefficiencies, and frustration among healthcare providers. Introducing better technical support, responsive system updates, and clearer communication channels would address these critical issues.

Revising forms and improving system functionality and support are the initiatives that will most effectively address the administrative burdens and inefficiencies within the HCAI system. These changes would streamline processes, improve communication, and ultimately allow healthcare providers to focus more on delivering quality patient care.

2. Are there any significant benefits/drawbacks, including potential stakeholder impacts, missing from the analysis set out above that should be included?

A significant drawback that needs to be addressed is the lack of confidence healthcare professionals have in the Financial Services sector and HCAI's ability to deliver meaningful improvements. After nearly two decades of nothing, there is no proven track record of HCAI

or the sector improving efficiencies or adequately consulting with healthcare professionals who use the system daily. Historically, these initiatives have been designed with the needs of insurers in mind, leaving healthcare professionals as an afterthought. This has resulted in a system that imposes significant administrative burdens on providers, which have no method to deal with any additional costs since their rates are fixed. This ultimately detracts from their ability to focus on patient care.

Without a genuine effort to include healthcare professionals in the redesign and improvement process, there is little confidence that any proposed changes will result in meaningful benefits for providers. In fact, any further administrative requirements or complex systems could increase costs for clinics and healthcare professionals, who already face significant challenges in managing these inefficiencies. Unlike insurers, who can simply pass on increased costs to consumers through premium hikes, healthcare professionals do not have the luxury of absorbing additional administrative expenses without harming their operations or affecting patient care.

To ensure they get it right, FSRA and HCAI need to make healthcare professionals a focus in the consultation process since they are the people inputting data into the systems and understand it's limitations. This means actively involving providers in the decision-making process from the beginning, ensuring their input is not merely a formality. Additionally, the new system must be tested rigorously with healthcare professionals to identify and rectify issues before full-scale implementation.

Another key element is transparency. FSRA must clearly outline how changes will specifically benefit healthcare professionals and demonstrate, through pilot programs or data-driven results, that the revised system will reduce administrative burdens without shifting costs onto providers. They must also ensure that any changes come with financial safeguards for healthcare professionals, such as ensuring that administrative inefficiencies aren't passed down as operational costs to clinics.

Without restoring trust and ensuring that healthcare professionals are not forced to absorb further administrative costs, the proposed changes may fail to achieve their intended outcomes. Direct involvement, accountability, and transparent testing processes are crucial to overcoming this long-standing issue.

3. Are there any considerations which have been missed as part of the analysis set out above that should be included?

As a clinic owner and healthcare professional, there are several critical issues with the current invoicing system and treatment program rigidity that need to be addressed:

1. Overly Complex Invoicing:
The invoicing process is far too complicated, with different invoice types (OCF-21B, OCF-21C, etc.) and codes that are so granular they become almost unusable. These codes are difficult to keep track of, especially for office administrators who usually handle the invoicing process. Expecting non-clinicians to navigate these complex coding structures introduces a high risk of errors and delays, leading to rejected claims and delayed payments, which ultimately impact the clinic's financial stability. Only one invoice type is required, and codes should be simplified.

2. Administrative Bottleneck:
In all sectors, invoicing is delegated to an office administrator who will not have a technical or clinical knowledge of the product or service to the extent the professional does. So, invoicing must be simple and not cumbersome and involved. The product or service can be complicated but invoicing needs to be simple.

The current system, which requires detailed and specific codes for each treatment, is too technical and prone to confusion, that certain required fields often disappear when a change to another section is made means submissions that look good prior to being sent are incomplete after being submitted. Simplifying the invoicing system would allow administrators to focus on efficiently managing claims rather than deciphering unnecessary complexities. It would also reduce the administrative burden on healthcare professionals, allowing them to focus more on patient care.

3. Lack of Flexibility in Treatment Plans:
Once a treatment program is approved under the HCAI system, there is little flexibility to make adjustments based on the patient's evolving needs. A patient may require more of one type of treatment on a particular day, and less of another, but the current rigid invoicing system forces clinicians to stick to pre-approved treatments and quantities. This lack of flexibility hampers the clinician's ability to adapt to the patient's real-time needs, which is crucial for achieving the best clinical outcomes.

4. Impeded Clinical Judgment:
The inability to modify treatment within approved plans without triggering complications with invoicing takes away from a clinician's ability to make judgment-based decisions. For instance, if a patient needs more manual therapy on a particular day but less electrotherapy, the therapist is constrained by the pre-approved plan and may avoid adjusting the treatment plan due to concerns about rejected invoices. This rigidity detracts from optimal patient outcomes as clinicians are restricted in tailoring care to individual patient needs.

5. Stifling of Adaptive Care:
Effective rehabilitation often requires ongoing assessment and adaptation of treatment plans. The current HCAI system discourages this by locking treatments into predefined

categories, preventing clinicians from responding to changes in a patient's progress or condition. If the invoicing system allowed more flexibility within approved treatment blocks, clinicians could shift the focus of treatment depending on the patient's immediate needs without worrying about non-reimbursement.

6. Impact on Patient Outcomes:
The rigidity of treatment plans under the current system reduces the likelihood of achieving the best clinical outcomes. Healthcare professionals are best placed to decide on the day-to-day needs of their patients, but when the system dictates treatments too rigidly, it removes the clinician's ability to provide adaptive, responsive care. This not only impacts the patient's recovery but also reflects poorly on the clinic's ability to deliver quality care.

Simplifying invoicing and allowing greater flexibility within approved treatment plans would significantly enhance both operational efficiency and patient outcomes. The current system hampers clinical decision-making and creates administrative challenges that ultimately take away from delivering high-quality care. A more streamlined, flexible system would better serve healthcare providers, administrators, and most importantly, patients.

A Call to Action

The current state of the HCAI system hinders efficiency, burdens healthcare providers with excessive administrative tasks, and ultimately detracts from patient care. Healthcare professionals are committed to delivering quality care but require tools and systems that support rather than hinder their efforts. It's time for FSRA and other stakeholders to recognize the critical flaws in the HCAI system and take meaningful steps to address them.

By embracing modern technology, prioritizing user-friendly design, and fostering effective communication, we can transform HCAI from a red tape nightmare into a platform that genuinely facilitates efficient healthcare delivery. The opportunity for improvement is clear, and the benefits are substantial—not just for healthcare providers, but for insurers and patients alike. Efficient systems will lead to reduced administrative costs, which can help lower auto insurance premiums, ultimately benefiting consumers financially. Moreover, streamlined processes will enable healthcare providers to focus more on patient care, leading to better health outcomes and enhanced patient satisfaction.

The review of the Health Claims for Auto Insurance (HCAI) system reveals a deeply flawed framework that significantly hampers both healthcare providers and patients in Ontario. The core issue lies in the system's persistent reliance on outdated and overly complex processes, rather than adopting proven, efficient platforms already available, such as the TELUS Health eClaims portal utilized by the Workplace Safety and Insurance Board (WSIB). This continuous reinvention introduces unnecessary administrative burdens, driving up costs and diverting crucial resources away from patient care.

Key shortcomings of the HCAI system include:

- Excessive Complexity and Redundancy: The multitude of invoice types and detailed coding requirements create a labyrinthine process that is time-consuming and error prone. This complexity not only delays payments but also undermines the financial stability of healthcare clinics.
- Lack of Stakeholder Engagement: The system was developed without meaningful input from the healthcare providers who use it daily, leading to a disconnect between regulatory intentions and practical application. This oversight results in inefficiencies that directly impact patient care.
- Inadequate Communication and Support: HCAI's inability to facilitate effective communication and accept supporting documents within the platform exacerbates administrative delays and increases the risk of errors.

- Rigid Treatment Plans: The system's inflexibility restricts clinicians' ability to adapt treatment plans based on patient needs, thereby impeding optimal clinical outcomes and adaptive care.

The comparison with other systems, such as the TELUS portal, underscores that more user-friendly and efficient solutions are not only possible but already in practice. The HCAI system's shortcomings, including its inability to accept attachments and lack of real-time support, highlight a significant gap in meeting the needs of modern healthcare administration.

To address these issues, it is imperative that the Financial Services Regulatory Authority of Ontario (FSRA) takes decisive action to overhaul the HCAI system. Recommendations include simplifying forms and processes, enhancing communication channels, allowing the attachment of supporting documents, implementing real-time adjudication, providing transparency in decision-making, and automating recurrent claims. Additionally, involving healthcare professionals in the redesign process is crucial to ensure that the system truly serves their needs and facilitates efficient patient care.

Ultimately, reforming the HCAI system is essential to reduce administrative burdens, lower costs, and improve the quality of care for patients. By prioritizing proven, streamlined solutions and fostering collaboration between regulators and healthcare providers, Ontario can create a more effective and sustainable auto insurance claims system that benefits all stakeholders involved. It is time to redirect our efforts towards a path that enhances efficiency, supports healthcare professionals, and ensures better outcomes for patients and consumers alike.

> *"Any intelligent fool can make things bigger, more complex, and more violent. It takes a touch of genius – and a lot of courage – to move in the opposite direction."*
>
> *— E.F. Schumacher*

SECTION 4:

Final Section:

October 2024

The future of treatment isn't about cutting corners—it's about cutting through the red tape. When we invest in the people who care for us, we invest in a healthier, stronger Ontario. Let's build a system that values quality over cost, sustainability over shortcuts, and people over profits. That's how we all move forward.

Why Healthcare Professionals Are Skeptical of the FSRA as an Honest Broker in these consultations

Insights from a healthcare professional:

Healthcare professionals have expressed significant skepticism regarding the Financial Services Regulatory Authority (FSRA) acting as an impartial broker in these matters. This skepticism stems from a series of historical actions and inactions by the FSRA that suggest a potential bias favouring the insurance industry over healthcare providers. This perception on the part of healthcare professionals is based in a desire to keep premiums low at any cost – which seems to be detrimental to short term healthcare costs.

Understanding this perspective requires acknowledging that regulatory decisions are made by individuals who may hold inherent biases and preferences, like all people. We all hold biases, and if we worked in an industry, we would feel comradery and sympathy for our past colleagues in insurance.

Psychological research indicates that people often exhibit confirmation bias and resistance to changing their beliefs, even when confronted with logical arguments or new evidence. This human tendency can inadvertently influence policy decisions, leading to perceived unfairness.

The individuals within the organization influence the FSRA's decisions as do the mandates of previous government. Bias is an inherent human trait; without objective information and self-awareness, it can affect regulatory outcomes. The reluctance to adjust policies or consider alternative viewpoints may result from cognitive dissonance and people's natural difficulty in changing established beliefs or practices. FSRA has had no desire to look at accident benefits costs outside the myopic lens of the insurance industry and this is exemplified since its outreach to healthcare is limited or nonexistent.

Examples Illustrating Skepticism

1. Stagnant Rates and Guidelines: The Minor Injury Guideline (MIG) in Ontario has remained unchanged since 2010, with a cap of $3,500 for treatment. Despite medical inflation rising faster than the cost of living and salaries in insurance increasing with inflation and evolving licensing practices that require increased administrative burden time and resources, the FSRA has not adjusted these rates, which healthcare professionals argue does not reflect current economic realities or patient needs.

2. Unequal Financial Reimbursements During COVID-19: During the pandemic, the FSRA approved fee rebates for insurance companies, even as these companies reported record profits. Conversely, health service providers, such as physiotherapy clinics

mandated to shut down for three months, did not receive any financial considerations. Instead, they faced audits for providing virtual care, their only means of sustaining operations during lockdowns.

3. Lack of Engagement with Healthcare Providers: At the 2024 Financial Services Regulatory Exchange, not a single question from health service providers was addressed. This followed an incident at the 2023 exchange where the FSRA CEO and VP of Auto Insurance Products demonstrated their ignorance of the organization's role in setting professional service guidelines, raising concerns about the FSRA's understanding and prioritization of healthcare provider issues.

4. Burdensome Administrative Requirements that we don't see as correlating to fraud: The FSRA considers delays in updating administrative details, such as a change of address not provided within five days, as serious compliance issues potentially linked to fraud. Healthcare professionals view this as disproportionate and indicative of a punitive regulatory approach towards them. We have been stating for years that healthcare professionals are regulated by healthcare colleges and, therefore, are already regulated. The real lack of oversight is in businesses run by unregulated persons or with publicly traded companies that only have a fiduciary duty to shareholders.

5. Unaddressed Preferred Provider Networks Issues: Insurance companies have established preferred provider networks with their partners, who are also publicly traded companies, some of which have been reported in the media for charging referral fees. Healthcare providers have flagged this as an unfair and deceptive act, yet there has been little response or corrective action from the FSRA. Industry will typically respond and state these networks are open to everyone, but the experience is they are open only by invitation from an insurer and insurers choose who gets to enter and stay based financial considerations not care based outcomes.

6. Disbandment of Advisory Committees: The FSRA initially established a Health Service Provider Advisory Committee, which was applauded as a step towards collaborative regulation. However, the committee was disbanded less than two years later when the feedback provided did not align with the FSRA's existing perspectives, suggesting a reluctance to consider alternative viewpoints.

7. Selective Financial Relief: According to the 2021 FSRA Annual Report (page 43), the FSRA provided fee discounts to certain regulated sectors, including insurance companies. In contrast, health service providers did not receive similar relief despite facing significant operational challenges during the pandemic. This selective support raises concerns about impartiality and fairness.

8. Delayed System Improvements: The Financial services regulators, along with HCAI, have been quick to implement changes to systems like the Health Claims for Auto

Insurance (HCAI) based on insurance industry needs, as reported in industry publications. However, requests from healthcare professionals for system improvements, such as enabling monthly invoicing, had been acknowledged but not acted upon for years, making healthcare professionals feel our concerns were not important.

9. Inadequate Educational Efforts: A single 30-minute presentation over a decade of licensing by the FSRA was presented as a meaningful educational initiative. However, healthcare professionals note that their questions and suggestions from previous consultations have not been addressed, undermining the effectiveness of such efforts.

10. Proactive Changes Favoring Insurers: The FSRA has taken the initiative to change the speed of ratemaking processes to benefit the insurance market, even when not legally required to do so. Conversely, within this consultation, FSRA has stated that it has no legal obligation to adjust rates for healthcare professionals, highlighting a perceived double standard. While there is no specific legal requirement to make any innovations or systemic reviews, the agency seems significantly more aligned with the values and needs of insurance. Healthcare professionals expect a duty of care to the industry as a whole and especially to any licensed stakeholders.

11. The FSRA, in this consultation, promotes that one of its key performance indicators is auto insurance rates. This is a significant hurdle to long-term thinking and driving real change. Every short-term "solution" put forward since 2003 has had the same objective, and the result is a lack of focus on long-term solutions that can solve the problem. Healthcare professionals see a broken system from the ground and are being ignored by people in ivory towers talking to lobbyists in another ivory tower. We see the direct effect of short-term cost cutting in care and how it has resulted in increased costs in chronic pain, ODSP, legal fees, settlements and administrative costs. We know that the economic costs of chronic pain are three times more devastating to an economy than all cancers combined, yet the reason it does not get any attention is that nobody dies from chronic pain - they die from suicide - which I have personally seen.

The cumulative effect of these examples contributes to the healthcare professionals' belief that the FSRA is not acting as an honest broker. The perceived preferential treatment of the insurance industry, coupled with a lack of responsive engagement with healthcare providers, underscores concerns about impartiality and fairness in regulatory practices. Recognizing and addressing inherent biases within the FSRA's decision-making processes is crucial. Objective, evidence-based policy decisions are essential to restore trust and ensure that the needs of all stakeholders, including consumers, healthcare professionals and their patients, are fairly represented.

Healthcare professionals perceive these decisions as lacking common-sense, long-term vision, and based in fear. We look to government to address the behaviour of the agencies

and when agencies seemingly make two decades of bad decisions, it makes the government look bad in our eyes.

The real-world outcomes related to consumer recoveries after car accidents, coupled with rising auto insurance premiums despite reduced care costs over decades, speaks volumes. No matter how well-intentioned the original ideas may have been, we now find ourselves in a situation best captured by the phrase, 'the road to hell is paved with good intentions.' It's time to acknowledge this misstep and take decisive action to correct course.

Recognizing the Historical Wrongs and Injustices Done to Consumers

The landscape of Ontario's auto insurance framework has been shaped by several decades of policy decisions, regulatory changes, and legal precedents. While many of these developments were intended to protect consumers, the reality is that a series of missteps, oversights, and deliberate choices have resulted in an auto insurance system that frequently works against the very individuals it was designed to safeguard. The historical wrongs and legal injustices done to consumers within this system are deeply rooted in regulatory inertia, a lack of transparency, and a prioritization of corporate interests—specifically those of insurance companies—over the needs of patients and healthcare providers.

The Rise of the Minor Injury Guideline (MIG)

One of the most significant examples of legal injustice within the auto insurance framework is the introduction and implementation of the Minor Injury Guideline (MIG). Introduced in 2010 as part of an effort to reduce auto insurance costs, the MIG established a cap of $3,500 on medical and rehabilitation expenses for injuries deemed to fall under the category of "minor." This categorization includes a broad range of injuries, from soft tissue damage to whiplash and certain types of concussions.

The fundamental problem with the MIG lies in its blanket approach to injury treatment, lack of a review, lack of evidence of the appropriateness and the infliction. The MIG is a fee cap not a treatment program, healthcare professionals do not study how to get people better following a MIG, they are harmed by this cap as it limits treatment options based on financial limits that are arbitrary and over time encompass less and less.

By capping treatment costs at an arbitrary $3,500, the system effectively limits the ability of healthcare providers to deliver the number of sessions and comprehensive care many patients need to achieve full recovery. The guideline does not account for the individualized nature of injury and recovery; instead, it assumes that all minor injuries are uniform in severity and in the time and treatment required for rehabilitation. This approach fundamentally ignores the reality of any healthcare delivery, where a recovery trajectory can vary significantly based on a variety of factors, including pre-existing conditions, age, lifestyle, and the nature of the injury.

The financial cap has had a detrimental impact on consumers, many of whom find themselves trapped in a system that does not adequately allow for the care they require. Patients whose injuries are more complex than initially assessed are often forced to seek social assistance, pay out of pocket for additional treatment, or worse, are left untreated, leading to long-term health complications. The current framework surrounding the MIG

fails to provide patients with a **timely** avenue for appeal or reassessment, even in cases where the initial categorization of an injury as "minor" was inaccurate. This rigidity within the system constitutes a significant injustice, as it denies consumers the right to speedy resolutions, fair treatment or adequate care.

Systemic Underfunding of Care: The Stagnation of Fee Schedules

Another historical wrong that has contributed to the inequities in Ontario's auto insurance system is the stagnation of fee schedules for healthcare providers. The fees paid to physiotherapists, chiropractors, occupational therapists, and other healthcare professionals providing care to accident victims have remained largely unchanged since 1996. This failure to adjust compensation for inflation or the rising costs of delivering care has had a profound impact on both healthcare providers and patients.

In 1996, the hourly rate for physiotherapy services under the auto insurance system was set up to $120. However, in subsequent years, this rate was reduced to $84 per hour and remains at only $99.75 per hour today. This rate does not adequately reflect the true cost of delivering care, paying for only direct patient interaction not the charting healthcare professionals are legally obligated to do and is no longer sufficient address overhead costs of running a healthcare practice, such as rent, staff salaries, and equipment maintenance. For comparison, tradespeople such as electricians and plumbers often charge well over $150 per hour for their services—more than what healthcare providers receive for treating patients recovering from serious physical injuries.

The underfunding of healthcare services in the auto insurance framework creates an injustice. The failure to update fee schedules has essentially frozen healthcare providers in a financial system that does not reflect modern economic realities, and this has far-reaching consequences for the sustainability of healthcare practices and the quality of care they provide.

The Increase in Administrative Burden

Regulated Healthcare Professionals, must now navigate complex administrative and regulatory requirements in addition to providing care if they want to reduce the administrative burden for the accident victims they treat.

The introduction of the Health Service Provider (HSP) licensing system is a prime example of this shift. Under this system, healthcare providers must obtain a license to bill insurers directly for services provided to auto accident victims. The stated intent of the HSP licensing system was to reduce fraud within the auto insurance framework, but in practice, it has created additional layers of red tape and administrative burden for healthcare providers, without yielding significant improvements in patient outcomes or fraud prevention.

The HSP licensing system has imposed financial and administrative costs on healthcare providers, many of whom are already struggling under the weight of stagnant fees and rising operational expenses. For consumers, the effect has been equally detrimental. The increased administrative burden on healthcare providers often translates into delayed care, as providers must spend more time navigating regulatory hurdles and less time focusing on patient treatment. This, in turn, affects the quality-of-care patients receive and extends recovery timelines, all while failing to address the root causes of fraud and inefficiency within the system.

Perhaps most concerning is the fact that consumers are often unaware of the extent to which these administrative challenges affect their care. From a legal standpoint, the framework gives the appearance of consumer protection but has not added value to the existing healthcare regulation framework which is an already effective deterrent to fraud. Regulated healthcare providers and consumers bear the brunt of its inefficiencies.

The Lack of Recourse for Consumers

Ontario's auto insurance framework lacks a meaningful speedy recourse available to consumers who are denied care, which results in chronic pain flourishing. The system is heavily weighted in favour of insurers, who often have the time and financial and legal resources to contest claims, delay payments, and limit coverage. Consumers, by contrast, are often left with little recourse other than to navigate a lengthy and complex appeals process, which is both financially and emotionally draining.

The LAT process, which is supposed to provide a forum for resolving disputes between consumers and insurers, has also come under criticism for its lack of accessibility. Many consumers report feeling overwhelmed by the legal jargon and procedural requirements involved, and without the assistance of a lawyer, they are often at a significant disadvantage. This imbalance of power between insurers and consumers constitutes a legal injustice that undermines the very purpose of the arbitration process, which is to ensure fairness and accountability in the resolution of disputes.

A Call for Justice and Reform

The historical wrongs and legal injustices embedded within Ontario's auto insurance framework have left consumers and healthcare providers in a system that often fails to meet their needs. From the arbitrary limitations imposed by the Minor Injury Guideline to the stagnation of fee schedules, the system is riddled with inefficiencies and inequities that disproportionately affect auto insurance consumers who must pay for this red tape with forever increasing premiums.

Recognizing these historical wrongs is the first step towards meaningful reform. Consumers deserve a system that prioritizes their care and recovery, rather than one that

limits their access to necessary treatment through arbitrary caps and outdated policies. Healthcare providers, too, must be adequately compensated for the critical role they play in helping accident victims recover, and they should not be burdened with unnecessary administrative and regulatory hurdles that detract from their ability to provide care.

A reimagined auto insurance system—one that acknowledges the past and corrects its mistakes—must be built on the principles of fairness, transparency, and accountability. It is time to right the wrongs of the past and create a system that truly serves the needs of Ontario's consumers and healthcare providers.

Calling for Balanced Long-Term Solutions

Ontario's auto insurance system is at a crossroads. For decades, the focus has been on short-term fixes and reactionary policies aimed at controlling premiums, often at the expense of patient care and the overall sustainability of the system. This approach has led to a healthcare framework where costs are artificially suppressed, quality is compromised, and the long-term wellbeing of consumers and healthcare provider sustainability is neglected. The time has come to shift away from this short-term thinking and embrace balanced, long-term solutions that focus on systemic sustainability, better patient outcomes, and a more equitable distribution of costs and benefits among all stakeholders.

The Flaws of Short-Termism

The history of Ontario's auto insurance regulatory framework is littered with examples of short-term policies that, while politically expedient, have failed to address the root causes of inefficiency, high costs, and poor patient care. Governments, insurers, and regulators alike have been fixated on keeping premiums low as a key performance indicator, often without regard to the long-term consequences of these policies or the effect on the Ontario economy as a whole and in particular the per capita GDP.

One of the most telling examples of this short-termism is the repeated focus on suppressing the costs of medical treatment and rehabilitation services. By maintaining artificially low reimbursement rates for healthcare providers, the system has created a vicious cycle of underfunded care, leading to longer recovery times, increased chronic conditions, and a greater overall burden on the public healthcare system. While keeping premiums low may seem like a win for consumers in the short term, the reality is that it leads to higher costs down the line—costs that are borne by the healthcare system, the economy, and accident victims themselves.

The current focus on controlling premiums also overlooks the true cost drivers within the system. Administrative inefficiencies, duplicated assessments, and prolonged disputes over claims are far greater contributors to rising insurance costs than the fees paid to healthcare providers for treatment. Yet these systemic inefficiencies are rarely addressed in a meaningful way. Instead, the solution is often to cap fees, reduce services, or impose greater administrative burdens on healthcare professionals—all of which only serve to exacerbate the problem.

The Need for a Long-Term Vision

What Ontario's auto insurance system needs is a fundamental shift in focus—from short-term cost suppression to long-term sustainability and value. This requires a vision that prioritizes patient care and outcomes, recognizes the essential role that healthcare providers play in the recovery process, and addresses the true inefficiencies that drive up costs for insurers and consumers alike.

A key element of this long-term vision is the adoption of a **LEAN framework** for both regulatory oversight and care provision. LEAN principles focus on streamlining processes, eliminating waste, and delivering the most value with the least resources. In the context of auto insurance, this means cutting through the red tape that currently bogs down healthcare providers, and insurers, reducing duplicative and unnecessary assessments, and ensuring that almost every dollar spent on rehabilitation and medical care goes towards improving patient outcomes, not administrative overhead.

To achieve this, policymakers and regulators must begin to think holistically about the system. This involves understanding that investments in healthcare—much like investments in infrastructure—pay dividends over time. By ensuring that patients receive the care they need early on in their recovery, we can prevent long-term disability, reduce the incidence of chronic pain, and lessen the reliance on public healthcare services. This, in turn, lowers the overall cost burden on both insurers and taxpayers, creating a more sustainable system for everyone involved.

"Chronic Pain is Three Times as Costly to the Economy as all Cancers Combined"

Prioritizing Patient Care and Outcomes

At the heart of any long-term solution must be a renewed focus on patient care and recovery outcomes. The current system's preoccupation with keeping costs low has often come at the expense of quality care, with patients receiving less treatment than they need, or being funneled into treatment frameworks that prioritize cost savings over effectiveness.

This approach is not only ethically problematic but also economically shortsighted. Numerous studies have shown that providing patients with early, intensive, and high-quality rehabilitation leads to better long-term outcomes, including faster recovery times, a higher likelihood of returning to work, and a reduced need for ongoing medical care. By contrast, under-treating patients or limiting their access to necessary care results in longer recovery times, a greater likelihood of developing chronic conditions, and increased reliance on publicly funded healthcare programs like the Ontario Disability Support Program (ODSP) and chronic pain clinics.

In the long run, failing to prioritize patient care does not save money—it simply shifts the costs from the insurance system to the public healthcare system and, by extension, the

taxpayer. Worse still, it leaves many accident victims with long-term disabilities or chronic pain, reducing their quality of life and their ability to contribute productively to society.

This issue extends beyond auto insurance—it's evident in primary care within the government-funded system as well. The failure to adequately address healthcare needs through primary care cuts has led to a significant rise in downstream costs across government-funded programs. Accident victims don't simply disappear; their unmet needs drive up long-term costs for everyone.

A long-term solution must therefore place patient care at the centre of the auto insurance framework. This means ensuring that healthcare providers are adequately compensated for their services, that patients receive the full spectrum of care they need to recover, and that the system is designed to support—not hinder—the recovery process. By focusing on outcomes rather than costs, we can create a system that is not only more humane but also more cost-effective in the long run.

Addressing Systemic Inefficiencies

A critical component of any long-term solution must be the elimination of systemic inefficiencies that currently plague Ontario's auto insurance framework. These inefficiencies, which include duplicative assessments, administrative bottlenecks, and a reliance on outdated technologies, drive up costs for both insurers and healthcare providers, while offering little benefit to patients.

One of the most glaring examples of inefficiency within the system is the reliance on **dueling assessments**, where multiple healthcare professionals are required to evaluate the same injury or treatment plan, often with little to no coordination between them. This practice not only wastes time and resources but also delays patient care and recovery, as healthcare providers are forced to spend valuable time justifying their treatment plans rather than focusing on their patients.

Another area of inefficiency is the **Health Claims for Auto Insurance (HCAI) system**, which has been criticized for its outdated technology and cumbersome administrative requirements. The HCAI system, originally intended to streamline the billing and invoicing process for healthcare providers, has instead become a source of frustration and inefficiency. Healthcare professionals are often required to navigate complex and time-consuming processes just to submit a single invoice, and the lack of integration with other healthcare billing systems further exacerbates the problem.

Addressing these inefficiencies requires a concerted effort to modernize the auto insurance framework and reduce the administrative burden on healthcare providers. This includes investing in new technologies that can streamline the billing and claims process, eliminating unnecessary assessments, and creating a more collaborative approach to

patient care that reduces duplication and ensures that all stakeholders are working towards the same goal—improving patient outcomes.

Involving Healthcare Providers in Policy Development

One of the key reasons why Ontario's auto insurance system has struggled to find long-term solutions is the lack of meaningful involvement of healthcare providers in the policy development process. Healthcare professionals—those on the front lines of patient care—are often excluded from discussions about how the system should be structured, even though they are the ones most carrying out these policies.

This disconnect between policymakers and healthcare providers has led to a system that is often at odds with the realities of delivering care. For example, the **Health Service Provider (HSP) licensing framework** was developed in opposition from the healthcare community, resulting in a set of regulations that impose significant administrative burdens on providers without addressing the actual needs of patients or the healthcare system. Similarly, the **Minor Injury Guideline (MIG)** was implemented without adequate consultation with healthcare professionals, leading to a rigid, one-size-fits-all approach that fails to account for the complexity of many patients' injuries.

To develop truly balanced, long-term solutions, policymakers must actively engage healthcare providers in the decision-making process. This means consulting with physiotherapists, chiropractors, physicians, and other healthcare professionals about the challenges they face in delivering care and using their insights to inform policies that are both practical and effective. By involving healthcare providers in the conversation, we can ensure that the system is designed to meet the needs of patients and auto insurance consumers, rather than being dictated by the narrow interests that are detrimental to long term sustainability for insurers.

Appendices

Appendix A: MIG EXPLAINED

Fee-capped programs, such as the Minor Industry Guidelines (MIG), are in effect limiters on the cost of care. They're developed by industry stakeholders to govern the expenditure in healthcare. They are a ceiling on how much can be spent on certain types of care.

Now, consider the role of a physiotherapist. One of their fundamental treatment goals is functional restoration, which means helping patients regain their normal function, regardless of how big or small their health issue is.

Functional Restoration Goals are not the only types of goals required from treatment within the SABS.   (A short list and description of some types of goals are included below)

The Minor Injury Guideline is a functional restoration model of care. But it is important to understand that this isn't a specific treatment plan. It doesn't tell the healthcare professional to do A, B, and C in a certain way. In fact, doing so could be detrimental.

Instead, this model of care is more like a company's vision statement. It sets forth broad principles but doesn't dictate the day-to-day operations.

In essence, the MIG acts as a cap on treatment fees, often implemented through block billing. Even within these confines, it is still up to regulated healthcare professionals to decide on the best course of action. They strive to address patient'' needs as best as possible, but the block fee limits might prevent them from providing the best care.

The MIG is, therefore, a kind of monthly expenditure limit, which many stakeholders feel falls short of what is required for a patient to fully recover, based on the goals set in the Statutory Accident Benefits Schedule (SABS).

Healthcare professionals are tasked with doing their utmost to improve the patient's condition, particularly with complicated injuries. However, due to the rigid funding structure and lack of flexibility, they might not be able to provide optimal care.

The MIG structure often inadvertently sets many treatments up for failure because of the limit it indirectly sets on the frequency of therapist interventions via insufficient funding.

The inadequacy of the MIG is often missed because there is no follow-up tracking of patients once a treatment request denial. Other than specific approved fees paid by

insurers and submitted through HCAI there is no data confirming effectiveness as determined as a productive return to the taxpayer base or continued use of social services.

So, what we have in place now, the MIG, is somewhat like a straitjacket, constraining the full potential of what healthcare professionals can do to help their patients. Healthcare Practitioners statements that this limit on fees imposed by the MIG doesn't allow for the complete care necessary for full recovery, especially when dealing with complex injuries, have fallen on deaf ears.

The system is essentially set up in a way that can be limiting and, in many cases, detrimental to the patient's recovery journey. The professionals are left with the burden of maximizing what they can do within these restrictive blocks, a situation that may often leave the needs of the patients unmet.

Adding to this, there is an opaque veil over what happens to a patient once their treatment request claim is denied. While an insurance examination might be performed and recorded, subsequent treatments paid privately, or interventions funded by the government, legal fees, and settlements are not tracked in the system. Therefore, the actual cost associated with a patient's care and recovery goes significantly underreported.

The current accident benefits system allows for the "gaming of healthcare", often using pseudoscientific principles that can interfere with proper care. There is a need to empower healthcare professionals with sufficient funding to effectively treat patients, particularly in the early stages of injury. This can prevent conditions from escalating and causing more severe problems down the line.

In the end, the MI''s limitations on care and the complexities it introduces can result in healthcare autonomy being eroded, with treatment frequency being dictated by poorly funded fee schedules. This kind of healthcare rationing can lead to poor outcomes for patients, and the system's failure to track results or associated costs compounds the problem.

In essence, the current structures and processes of the statutory accident benefit system need to be reconsidered. They are unbalanced, unfair, and lead to inadequate care in the initial stages, along with unnecessary disputes and hidden costs. A more patient-focused, transparent, and adequately funded system is needed to ensure the best possible outcomes for patients.

Question:

Wouldn't it be insightful to gather and analyze data regarding the number of individuals initially treated under the Minor Injury Guidelines who eventually undergo an Independent

Examination, reach a settlement, or resort to the License Appeal Tribunal? This data could significantly illuminate the effectiveness, or potential shortcomings, of the current system.

Today's MIG, PSG, and Attendant Care Issues Explained Simply

Imagine you're given fifty dollars for gas and told to make it last for an entire month of driving. Fifteen years ago, maybe that would have gotten you through – just barely. But with today's prices and the higher cost of living, fifty dollars barely gets you through a week, let alone a month.

This is exactly what healthcare providers and patients face with the Minor Injury Guideline (MIG), Professional Services Guideline (PSG), and attendant care limits. The fifty-dollar "budget" from years ago remains the same, while costs and patient needs have only grown. Just as fifty dollars of gas no longer gets you where you need to go, these outdated guidelines and limits prevent healthcare professionals from providing the level of care patients truly require, leaving everyone stuck far short of the destination.

In physiotherapy, various types of goals are set to address the needs of the individual patients and work towards improving their overall function and well-being. Here are some common types of goals in physiotherapy:

1. Pain Management Goals: These goals focus on reducing or managing pain levels experienced by the patient. The aim is to alleviate discomfort, improve mobility, and enhance the patient's ability to perform daily activities without excessive pain.
2. Mobility and Range of Motion Goals: These goals are designed to enhance the patient's ability to move their joints freely and improve flexibility. This can involve exercises and stretches to increase the range of motion.
3. Strength and Endurance Goals: These goals aim to improve muscle strength and endurance. Strengthening exercises are prescribed to enhance the patient's ability to perform physical tasks and prevent fatigue.

4. Balance and Coordination Goals: Patients with balance and coordination issues may work on exercises to improve their stability and reduce the risk of falls.

5. Functional Independence Goals: The focus here is on helping patients regain independence in daily activities, such as dressing, grooming, cooking, and household chores.

6. Posture Improvement Goals: Correcting posture-related issues can be a significant goal in physiotherapy, particularly for patients with chronic back or neck pain.

7. Cardiovascular Fitness Goals: These goals involve exercises that aim to improve cardiovascular fitness and overall endurance.

8. Gait Training Goals: For patients with walking difficulties, gait training is crucial to improve their walking pattern and make it more efficient and stable.

9. Neuromuscular Re-education Goals: Patients with neurological conditions or injuries may require retraining of specific muscle groups and motor patterns to regain lost function.

10. Education and Self-Management Goals: Patients may set goals related to understanding their condition better, learning self-management techniques, and preventing future injuries or relapses.

4. Psychosocial Goals: These goals address the psychological and emotional aspects of a patient's rehabilitation journey, such as reducing anxiety or depression related to their condition.
5. Sports-Specific Goals: Athletes or individuals looking to return to specific sports or physical activities may have tailored goals focused on sports-specific training and injury prevention.
6. Patient-Centered Goals: Individualized goals are crafted based on the unique needs and desires of the patient, taking into account their lifestyle, preferences, and priorities.

Appendix B

Ontario regulator says new Minor Injury Guideline must apply to at least 55% of minor injuries for auto insurers to turn a profit

July 29, 2010 by Canadian Underwriter

https://www.canadianunderwriter.ca/insurance/ontario-regulator-says-new-minor-injury-guideline-must-apply-to-at-least-55-of-minor-injuries-for-au-1000380831/

Ontario's insurance regulator has told industry defence counsel that 55% to 65% of all non-catastrophic, minor injury claims would need to fall within the province's new Minor Injury Guideline (MIG) in order for auto insurers to turn a profit.

Due to be implemented on Sept. 1, 2010, Ontario's auto reforms have introduced a hard cap of $3,500 on all minor injury claims.

The reforms include a new Minor Injury Guideline (MIG), which establishes a three-stage treatment framework for minor injuries. The MIG replaces the old Pre-Approved Framework (PAF) for Grade I and II Whiplash Associated Disorders, which never really applied to as many minor injuries as initially intended.

Appendix B: Ontario Regulator say new Minor Injury Guideline must apply to at least 55%

Insurers have told Canadian Underwriter in the past that the PAF was originally intended to capture roughly 80% of minor whiplash injuries. But at least one insurer has said it ultimately applied to less than 2% of their claims; others have cited numbers less than 5%.

Given the PAF experiences above, most people attending an Ontario Insurance Adjusters Association (OIAA) seminar on the reforms in Toronto on July 29 expressed disbelief that the MIG injuries would meet the Financial Services Commission of Ontario (FSCO)'s projected targets.

"We've been told by FSCO that 55% to 65% of all claims need to fall within the MIG in order for the new premium structure to make it so that Ontario insurers are not working at a loss," said Kadey Schultz of Hughes Amys, who provided a broad overview of the province's auto accident benefit reforms. "That's just impossible. We are never going to see 55% to 65% of cases fall in the MIG."

Schultz's presentation cited a number of reasons for claimants' injuries to fall outside of the MIG, including the potential for psychological complaints and pre-existing conditions, to name a few.

"So the idea that the new SABS is more economically viable for an insurer than the old SABS, my respectful opinion is that we have missed the ball on that completely," said Schultz.

Appendix C:

Application of Ontario's Minor Injury Guideline is "crazy right now": AB lawyer

February 9, 2012 by Canadian Underwriter

https://www.canadianunderwriter.ca/insurance/application-of-ontarios-minor-injury-guideline-is-crazy-right-now-ab-lawyer-1000894320/

The application of Ontario's new Minor Injury Guideline
(MIG), which defines the scope of minor injuries sustained in vehicle collisions, is "crazy right now," according to Kadey B.J. Schultz, partner with Hughes Amys LLP.
In some instances, she said, the MIG protocol is being applied to files that include injuries such as fractures, complete tears and very serious psychological complaints.
Schultz spoke at the Ontario Insurance Adjusters Association's (OIAA) 2012 Professional Development & Claims Conference in Toronto on Feb. 8.

If a claimant has a fracture, an insurer cannot, in Schultz's opinion, be placed in the MIG, which is a treatment protocol that includes a $3,500 cap on insurance payments for minor injuries.

Nor can an insurer pay for the treatment of a fracture injury for the full duration of the staged treatment process defined in the MIG, and then re-instate new treatment of the fracture using a subsequent OCF 18 (treatment and assessment plan), she added.
"You're either in the MIG, or you are out of the MIG," she said.

Insurers and the province's insurance regulator, the Financial Services Commission of Ontario (FSCO), are trying to capture the minor injuries and treat them within the MIG protocol whenever possible, she said. "The MIG is something that needs to be applied aggressively, assertively, but it has to be applied correctly."

Appendix D:

Minor Injury Guideline Refresher

March 31, 2012 by John Malatesta, chiropractor with Sibley & Associates

https://www.canadianunderwriter.ca/features/cc-minor-injury-guideline-refresher/

The Financial Services Commission of Ontario (FSCO) initially released the Minor Injury Guideline (MIG) in June 2010, and then followed up with a revised MIG that took effect November 2011. Overall, the MIG provides a FSCO-approved process for the treatment of uncomplicated musculoskeletal injuries resulting from a motor vehicle accident. The purpose of the MIG is to help expedite treatment by providing a pre-approved process, and as a result avoid delays due to lengthy approval requirements.

In terms of intent, the MIG is similar to FSCO's Pre-approved Framework (PAF) guideline, released in 2003, but the MIG provides a more concrete definition of soft tissue injuries. In some ways, the MIG could be thought of as 'tightening up' soft tissue injury definition offered by the PAF guideline. However, there still appears to be confusion around 'which injuries are in' versus 'which are out.' To get a better handle on what injuries are included in the MIG versus excluded, here is an MIG refresher.

Before 1990, all benefits were resolved solely through law suits in the courts by way of what is known as a "tort action." Then in 1990, the Ontario Motorist Protection Plan, Bill 68, became law introducing no-fault insurance and restricting the ability to sue—and establishing accident benefits. Fast forward to 1993 and Bill 164, the Insurance Statute Law Amendment Act, became law, expanding accessibility to accident benefits and introducing the Designated Assessment Centre (DAC) system. Then from 1994 to 2010, we saw the following developments:

• 1996: Automobile Insurance Rate Stability Act, Bill 59: allowed motor vehicle accident victims to be compensated for their losses through the courts by way of a tort action and/or from their insurer through no-fault coverage.

• 2003: Bill 198, Pre-Approved Framework (PAF) Guideline for Grade I and Grade II Whiplash Associated Disorders: outlined specific protocols for accessing treatment for whiplash associated disorders (WAD I and WAD II) without requiring prior insurer approval to start treatment, providing an overview of the expected course of treatment with a focus on maintaining normal daily activities.

• 2007: Revised Pre-Approved Framework (PAF) Guideline for Grade I and Grade II Whiplash Associated Disorders was introduced to improve the initial 2003 PAF guideline. At this time, the DAC system was eliminated because assessments

were costing more than treatment.

• 2010: MIG: Superintendent's Guideline No. 02/10 was introduced to tighten up the PAF definition of soft tissue injury and expedite treatment of soft tissue injuries

This brings us to where things now stand with the revised MIG, November 2011.

What is the MIG based on and how does the Functional Restoration Model fit in?

The MIG was developed in consultation with insurance industry stakeholders, healthcare professionals and legal representatives drawing extensively on findings identified by the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. According to the task force, "for both WAD and other neck pain without radicular symptoms, interventions that focused on regaining function and returning to work as soon as possible were relatively more effective than interventions that did not have such a focus." [1]

Accordingly, the MIG is based on the functional restoration model with a structured 12-week program broken into three phases. The focus of the functional restoration model is to not only provide your client with the knowledge to effectively self-manage their condition, but most importantly, to reduce

the risk of developing chronic pain. Based on the functional restoration model, treatment should include active care—only using passive modalities with the intent of promoting active care—all supported by education including self-management and coping strategies. Essentially, the goal of the MIG is not necessarily to completely resolve the injury in 12 weeks but rather to provide your client with the knowledge, education, and strategies to help them return to full function within a reasonable amount of time.

What is considered a minor injury?

The MIG outlines two criteria that must be met for an injury to be considered a minor injury and included in the MIG: (1) The injury must fall within the MIG definition of minor injury and (2) there must be no "compelling evidence" of a pre-existing injury that could prevent recovery of minor injuries within the MIG cap of $3500.

MIG definition of minor injury: The MIG defines a minor injury as "a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelea. This term (minor injury) is to be interpreted to apply where a person sustains any one or more of these injuries." Accordingly, the following injuries would not be considered a minor injury and would be excluded from the MIG:

Whiplash Associated Disorder Grade III: This refers to a neck complaint where there is objective evidence of neurological involvement within the physical findings and/or radiographic findings. These findings would result in the injury being excluded from the MIG.

Whiplash Associated Disorder Grade IV: This refers to a neck complaint with an associated fracture or dislocation. Radiographic evidence of a fracture/dislocation would result in this injury being excluded from the MIG.

Grade III Ligament or Musculotendonous Tear: This refers to a full tear of the ligament or muscle. Radiographic evidence of tear, with clinical correlation, would exclude this injury from the MIG. In addition, although Grade III ligament tears of the spine are rare, it is a very serious injury associated with spinal instability typically involving emergency surgery.

No pre-existing condition that could delay recovery: to be considered a minor injury, in addition to meeting the MIG's definition of minor injury, there must be no "compelling evidence" of a pre-existing injury that could prevent recovery of minor injuries within the MIG cap of $3500. Put another way, a pre-existing injury/illness might exclude your client from the MIG if there is "compelling evidence" that the pre-existing illness or injury could delay healing of the minor injury beyond the expected recovery timeframes.

In terms of determining "compelling evidence," according to the MIG, it is the responsibility of the healthcare provider who is submitting the OCF-18 to provide "compelling evidence" that a pre-existing illness/injury excludes your client from the MIG. For example, if your client had any of the following conditions an Insurer Examination would be necessary to determine whether these pre-existing conditions are compelling enough to prevent healing within normal timeframes—everything from medical conditions like diabetes, stroke, and heart disease to degenerative changes like disc disease, joint disease or prior musculoskeletal injury to psychological impairments or neurological conditions, as well as conditions like pregnancy and obesity.

Now what about the Revised MIG that came into effect November 2011?

As explained by FSCO, "The revised MIG provides direction for billing practices when a claimant changes health practitioners within the MIG, and direction on the integration of extended health care benefits with the MIG." Apparently, FSCO had received numerous questions about this situation because, as they describe, "The first practitioner often bills for the entire Block amount for treatments leaving the claimant with no funds for additional treatment under that Block with their new practitioner. To address this issue the MIG has been amended to provide that where a claimant

changes health practitioners, the first health practitione
r may only bill 25% of the amount otherwise payable for a Block for each week or part week in which that health practitioner provided treatment under the Block."[2]

End Notes

1. Source: Spine: 15 February 2008 – Volume 33 – Issue 4S – pp S5-S7
2. Source: FSCO Bulletin: Revised Minor Injury Guideline, October 19, 2011 http://www.fsco.gov.on.ca/en/auto/autobulletins/2011/Pages/a-06-11.aspx

Appendix E:

MIG Schmig

May 1, 2014 by James Cameron President, Cameron & Associates Insurance Consultants and Carol Jardine, Independent Insurance Executive and Consultant

https://www.canadianunderwriter.ca/features/mig-schmig/

What is all the fuss about?

When major reforms to Ontario's Statutory Accident Benefits Schedule (SABS) were introduced in 2010, probably the most critical component to reducing the cost of automobile insurance at that time was the introduction of the Minor Injury Guideline (MIG).

Multi-disciplinary medical experts globally had opined that about 80% of soft-tissue injuries from motor vehicle accidents should resolve with limited or no treatment within six to eight weeks. However, under the prior SABS, the average cost of medical treatment had escalated to unacceptable levels in the tens of thousands of dollars.

Is the system doing a better job today of maintaining the cost of treatment in line with the expected medical outcomes?

The MIG provides up to $3,500 of medical and rehab treatment incurred, eliminating the previous treatments

$2,250. By focusing on active treatment to facilitate prompt recovery and to contain the costs of treatment for minor injuries, the goal is to manage the ever-increasing cost of auto insurance in Ontario.

MEETING EXPECTATIONS?

The Financial Services Commission of Ontario (FSCO) previously reported its rate proposal calculations for the 2010 changes to the SABS assumed that 55% to 65% of injury claims would stay within the MIG. It was not clear if "stay" meant to stay within the $3,500 cap or within the actual prescribed treatment modules, totalling $2,250.

Some insurers have been firmly interpreting the MIG in line with medical evidence and treating 80% of their SABS claims (the soft-tissue injuries) within the MIG. Others have moved closer to FSCO's expectation of 55% to 65%.

If insurers at the outset of a claim are treating 80% of their clients in the MIG, what happens as these injuries mature? If the claim is open, and the claimant has or intends to dispute the MIG determination, or seeks or attends more treatment outside the MIG parameters, what goes on? Are insurers being flexible and responsive to allowing more treatment outside the MIG to get the injury healed and the claim closed? If not, do they continue to dispute the treatment

claims through mediation and arbitration?

The Health Care Auto Insurance (HCAI) system tracks all treatment activity and invoicing of health care services provided to auto accident victims. It became mandatory for insurers and treatment facilities to use HCAI in February 2011.

Through Insurance Bureau of Canada (IBC), HCAI provided statistics on injuries assessed by health care practitioners that strains and sprains represent 67% to 75% of all injuries reported through that facility. Interestingly, however, as the claim and injury matures, fewer claims are identified as MIG.

As a result, for accident year 2011, only 23% of the claims for strains and sprains remained in the MIG, with 47.5% receiving MIG and non-MIG treatment.

The chart on page 61 – courtesy of Willie Handler of Willie Handler and Associates – offers some numbers with respect to claimants by type of treatment.

If the claim starts in the MIG, it stays in the MIG; if the injury does not recover or takes on a psychological component, this takes it outside the MIG.

Insurers still do not have a clear ruling on the MIG determination and neither do claimants. The claimant's

counsel feels that it is in the client's best interest to introduce issues that defy the MIG guideline. Insurers may practise cost containment and not recognize pre-existing conditions that are alleged to take a client outside of the MIG. The claimant's counsel then files the dispute resolution process documents.

The claim, if it fails in mediation, will fall into the backlog of about 15,000 arbitration matters or into the growing number of SABS claims in litigation.

INSIDE OR OUTSIDE?

What is the impact of a claim being outside the MIG? Increasing costs and availability of health care, as well as access to as much as $50,000 of medical and rehabilitation costs.

Attendant care, one of the most rapidly increasing costs of the SABS prior to 2010, is not available for claims that fall within the MIG. If the claim falls outside the MIG, these benefits become available and may be assessed retroactively – or this may make for a more fulsome tort claim, as health care costs not paid by the SABS insurer become part of the tort claim.

For plaintiff counsel, why not pursue the SABS carrier? The medical evidence gathered at the expense of the SABS may,

in turn, allow the argument that the injury pierced the tort threshold for a bodily injury (BI) claim?

The question is: What are insurers reserving for? What are the leading indicators that a claim is not MIG-treatable? How many insurers actually know how the MIG is performing? How many of the closed files were closed within the MIG? Is the system meeting the 55% expectation by FSCO in the 2010 rates? Will the system see significant loss development on those claims as they crawl through the arbitration process?

Desjardins Insurance, Aviva Canada and others are growing their in-house counsel groups to help manage their costs of arbitrating or litigating. The older the claim, the more exposed an insurer is to increasing loss costs and defence costs.

WHAT IS THE EXPOSURE?

Where are the reserves for this exposure? Are they in the case reserves, in the actuarial calculation of incurred but not reported, or in a provision for adverse development? For example, Company A has 1,000 claims open for accident year 2012, but at end of 2014, 70% of the open claims are identified as still within the MIG.

Compare this to FSCO's 55%, and the difference between a

MIG claim at $3,500 and a non-MIG maximum of $50,000, and this results in a calculation of $47,500 times 150 claims. That totals $7.125 million.

Even using IBC's figure of the average cost of a SABS claim in Ontario in 2011 ($28,978), this number is $3.8 million. These are very significant numbers even before adding legal costs. Are the reserves reflected as the industry complies with rate reductions?

This is a question that should be a concern to all insurers. Are the right discussions happening between the claims department and the actuaries? Are the right statistics being tracked? How many of the more than 15,000 cases still in dispute are MIG challenges?

The Ontario Rehab Alliance, a non-profit organization of 97 health care firms employing more than 4,000 professionals, concluded from the stats that "people with injuries that are more serious than a simple strain are being treated inappropriately in the MIG."

The alliance argues that money would be better spent on treatment than disputes, and point out that "delays in treatment generally result in poorer outcomes over time."

TREATMENT OR MONEY?

Justice Donald Cunningham, former justice with Ontario's Superior Court of Justice and author of the then interim (since finalized) report on the Ontario Automobile Insurance Dispute Resolution System Review, spoke at a recent seminar on the current disputes (more than 15,000 cases) that have moved from the mediation process to arbitration. Cunningham opined that the pursuit of accident benefits should be about treatment, not about money.

However, if the dispute is still ongoing three years after a claim is made and that dispute is about whether or not a treatment request for an injury could be in the MIG, it is too late for treatment unless already incurred. It can only be about money.

What happens if too many injuries are taken out of the MIG during arbitration? Commenting on Scarlett v. Belair, a recent decision of the Court of Appeal for Ontario, plaintiff's counsel Littlejohn Barristers concluded the following: "Overall the Scarlett decision is significant, as it creates a framework to defeat the MIG."

The worst-case scenario is that the MIG outcomes fall below 55%. A
series of bad outcomes in arbitration or court cases could be a major setback.

Add to that that these expectations were calculated well before the most recent politically motivated implementation of a further 15% reduction in rate.

Among FSCO's goals, as expressed in its just-released Statement of Priorities for 2014, is to review the MIG protocol. FSCO has contracted scientists and medical experts to develop an evidence-based protocol to treat auto accident claimants who sustain minor injuries. The protocol will help to inform the Superintendent when developing a revised MIG.

FSCO also promises to review the HCAI system to determine what reports are necessary to provide additional information on statutory accident benefits treatment trends.

Both of these efforts may assist the industry and government to get it right.

In the interim, everyone is talking about adverse developments in Ontario auto BI claims. But is enough recognition being given to the potential for adverse development in the MIG?

Appendix F:

The hidden cost of Ontario auto accident injuries

December 16, 2019 by Greg Meckbach

https://www.canadianunderwriter.ca/legislation-regulation/the-hidden-cost-of-ontario-auto-accident-injuries-1004171840/

More than half a million Ontarians receive some form of government disability support and an advocate for claimants suggests many of these are caused by motor vehicle accident injuries.

"At the end of the day, unpaid claimants don't just go away. They end up on public support," said Rhona DesRoches, chair of the board of FAIR Association of Victims for Accident Insurance Reform, in a recent interview with *Canadian Underwriter*.

DesRoches was commenting on the annual cost to taxpayers of running the Ontario Disability Support Program. That cost rose 75%, from $3.1 billion in 2008/09 to $5.4 billion last year, Auditor General Bonnie Lysyk wrote in her annual report, released Dec. 4. The province's population hit 14.56 million this past July.

disabled, in which case they must have a "substantial physical or mental impairment that is continuous or recurrent and expected to last one year or more." This must result in a "substantial reduction" in either the person's ability to attend to their personal care or their ability to function in the community and in a workplace.

It is fair to say more than 30% of people who are injured in accidents in Ontario get some form of support from ODSP, said DesRoches.

The auditor general's report found that the Ministry of Children, Community and Social Services, which runs ODSP, had neither investigated nor studied key reasons why the growth in the number of people on ODSP support has substantially outpaced population growth. While the province's population grew 12% from 2008 to now, the number of people benefiting (claimants and their families) from ODSP grew from 342,100 in 2008/09 to 511,200 in 2018/19.

"A lot of it can probably be attributed to [motor vehicle] accident victims who are being sloughed off on to ODSP," DesRoches said.

This is especially true with a series of reforms made in the 2010 time frame, such as the $3,500 cap on coverage for

injuries that fall under the minor injury guideline, suggested DesRoches.

FAIR is concerned about clients' auto accident benefit claims being denied after insurers hire their own medical examiners to conduct file reviews.

"When people can't get the resources they need for recovery, generally they start off on welfare and then welfare pushes them toward Ontario Disability Support Program," said DesRoches.

FAIR is concerned about the possibility that in response to the auditor general report, the government might make it more difficult to qualify for ODSP.

"If the government makes it more difficult for accident victims to qualify for ODSP, where are they going to go?" said DesRoches. "The sad part of this is, people end up on ODSP and they also end up at food banks that are sponsored by the insurer who wouldn't pay them in the first place. It's an awful thing for accident victims to end up in that circumstance. It could be you or I."

In its report, the Office of the Auditor General said the Ministry of Children, Community and Social Services did not have a process to "assess the appropriateness of disability approval decisions." In nearly one in five applications

reviewed by Auditor General staff, it was not clear from the application and the adjudicator's rationale how the applicant met the definition of a person with a disability, according to the report.

Corporate Services Division
Supply Chain and Facilities Branch, Subrogation Unit

June 2015

Who Pays for Health Care: Injuries from Motor Vehicle Accidents

When a person is injured in a motor vehicle accident, the Statutory Accident Benefit Schedule requires the automobile insurer to pay for non-professional health care services (such as personal support and homemaking services, attendant care services, and community support services). These services may be provided at home or in community settings such as supportive housing units, long-term care homes and complex continuing care hospitals.

Typically, non-professional services can be arranged or provided through local Community Care Access Centres (CCACs), long-term care homes or other third-party agencies funded by the Ministry of Health and Long-Term Care (ministry). Clients who may require these services include those with serious or catastrophic physical injuries, closed head or acquired brain injuries and the elderly.

Automobile insurers should arrange non-professional health services for their clients and pay the service provider directly.

It is only after statutory accident benefits have been exhausted, or the level of service required exceeds specified maximums, that the ministry may consider funding these services, subject to assessment of the client and applicable ministry limits.

The ministry's subrogation unit is responsible for monitoring compliance of payment responsibility for persons injured in motor vehicle accidents and who require health services.

The Ministry of Health and Long-Term Care pays for:	
➢ Medical costs (all physician services) ➢ Hospital services ➢ Mental health facilities ➢ Air ambulance ➢ Several professional in-home health services such as nursing, occupational therapy, physiotherapy, speech-language pathology, social work and nutritional services provided in a range of settings including the home, school or community ➢ Any other ministry-funded services not covered under the Long-Term Care Act, 1994	➢ Community Support Services, such as; Meals and transportation: • Caregiver support • Home maintenance and repair • Social or recreational services ➢ Attendant Care/Personal Support/Homemaking Services, such as; Assistance with activities of daily living • Assistance with personal hygiene • House cleaning, laundry • Preparing meals

Up to specified maximum limits (e.g. $3000 - $6000 per month and $72,000 per year to a maximum of $1 million if a catastrophic injury for attendant care; $100 per week for homemaking).

Page 2 of 2

Priority of Payments

When someone is injured in a motor vehicle accident, the priority of payment for health care services is:

1. ministry programs:
   - OHIP services
   - professional services arranged or provided through CCACs such as nursing, physiotherapy, occupational therapy, speech-language pathology, social work and nutritional services (subject to eligibility and maximum amounts payable);
2. private supplementary health and disability insurer and private employer plans;
3. automobile insurers (statutory accident benefits available through injured person's own automobile insurance policy);
4. money awarded in a lawsuit;
5. provincial government plans are the last payer for:
   - non-professional services arranged or provided through CCACs such as personal support and homemaking services, attendant care services;
   - all services and benefits such as vocational rehabilitation and welfare payments, administered by the Ministry of Community and Social Services.

Recovering Health Care Costs

If the ministry has provided services, such as attendant care or personal support and homemaking, (that should have been paid for by the automobile insurer) the ministry will seek reimbursement directly from the automobile insurer.

Catalogue Number 014389

The automobile insurer should contact the service provider directly to negotiate and pay for services.

What You Can Do?

If your clients' injuries are due to motor vehicle accidents, you should know which organization should be paying for required health care services.

You can help by:

- knowing which health care services the Ministry of Health and Long-Term Care pays for, and which ones are paid directly by the automobile insurer
- ensuring your client has made a claim to his/her own automobile insurer
- verifying that your client has contacted the automobile insurer for provision and payment of attendant care, personal support and homemaking services.

If you have questions about health services and motor vehicle accidents, or would like more information, please call 613-548-6663.

The information on this fact sheet is not intended as legal advice. It is based on Legislation in the Insurance Act including amendments made through Bill 59 in November 1996. The contents are current as of today's date but are subject to change. Readers should satisfy themselves as to the currency/accuracy of the material at any particular time.

Appendix G: Ontario Subrogation Unit – Who Pays for Healthcare

Appendix H: 2022 Minor Injury CAP by Jurisdiction

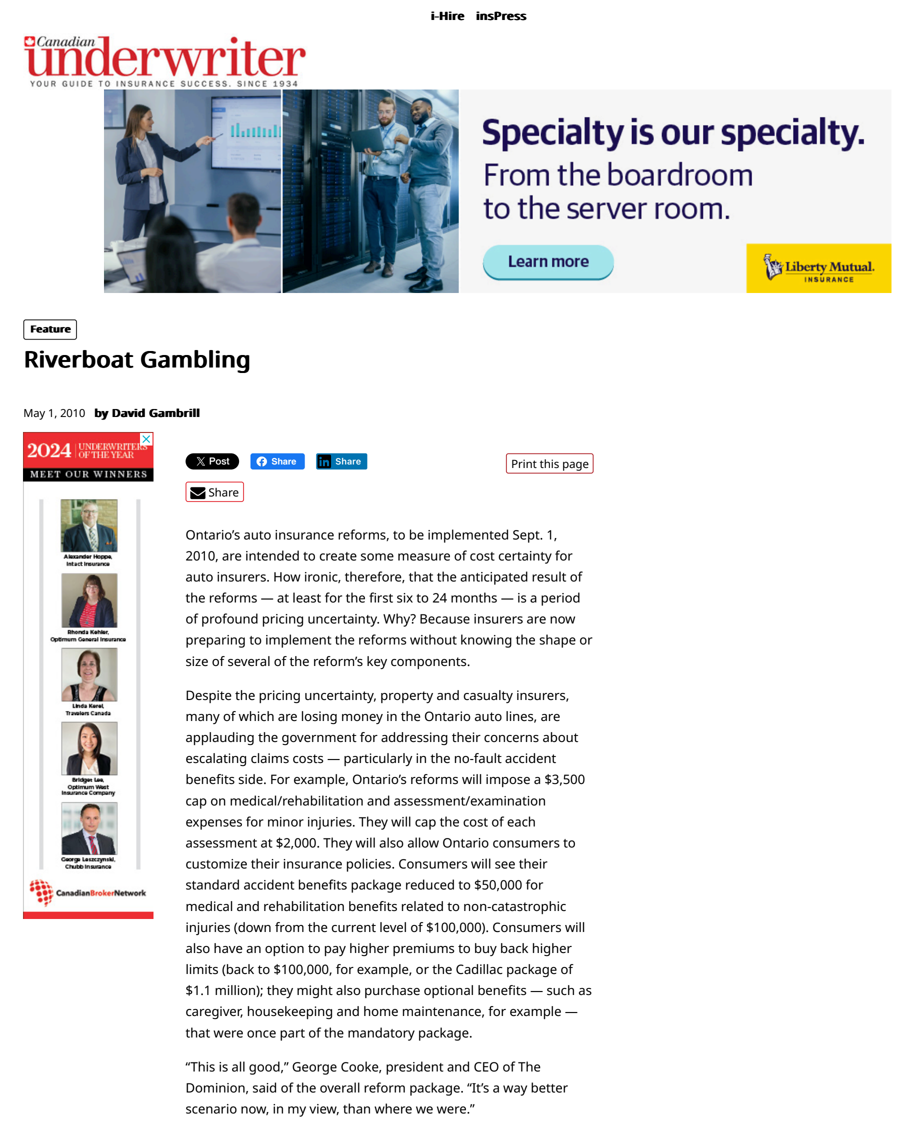
Appendix H: 2022 Minor Injury Cap by Jurisdiction

Province	Administration	Minor Injury Cap	Indexed?
NS	Private	$9,300	Yes
NB	Private	$8,638	Yes
PEI	Private	$8,358	Yes
BC	Public	$5,831	Yes
AB	Private	$5,488	Yes
MB	Public	Not applicable	Not applicable
NL	Private	No Cap (awards subject to $5,000 deductible)	Not applicable
ON	Private	$3500	Not applicable
QC	Public	Not applicable	Not applicable
SK	Public	No Cap (awards subject to $5,000 deductible)	Not applicable

Following changes to automobile insurance that took effect in British Columbia in 2021, injured drivers only qualify for minor injury compensation in rare circumstances.

- Adapted from Discussion Paper: Proposed changes to the Nova Scotia Auto Insurance Product - December 2022

Appendix I : Riverboat Gambling - Canadian Underwriter



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Feature

Riverboat Gambling

May 1, 2010 **by David Gambrill**

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Ontario's auto insurance reforms, to be implemented Sept. 1, 2010, are intended to create some measure of cost certainty for auto insurers. How ironic, therefore, that the anticipated result of the reforms — at least for the first six to 24 months — is a period of profound pricing uncertainty. Why? Because insurers are now preparing to implement the reforms without knowing the shape or size of several of the reform's key components.

Despite the pricing uncertainty, property and casualty insurers, many of which are losing money in the Ontario auto lines, are applauding the government for addressing their concerns about escalating claims costs — particularly in the no-fault accident benefits side. For example, Ontario's reforms will impose a $3,500 cap on medical/rehabilitation and assessment/examination expenses for minor injuries. They will cap the cost of each assessment at $2,000. They will also allow Ontario consumers to customize their insurance policies. Consumers will see their standard accident benefits package reduced to $50,000 for medical and rehabilitation benefits related to non-catastrophic injuries (down from the current level of $100,000). Consumers will also have an option to pay higher premiums to buy back higher limits (back to $100,000, for example, or the Cadillac package of $1.1 million); they might also purchase optional benefits — such as caregiver, housekeeping and home maintenance, for example — that were once part of the mandatory package.

"This is all good," George Cooke, president and CEO of The Dominion, said of the overall reform package. "It's a way better scenario now, in my view, than where we were."

George Cooke's predictions from 2010 have largely materialized in Ontario's auto insurance framework by 2024, according to insights from the FSRA consultation document. His concerns about inadequate definitions for injury classifications and the potentially harmful effects of rigid caps on minor injuries have proven accurate. Over the past decade, these rigid classifications and fee caps have increased administrative complexity, hindered appropriate patient care, and driven up costs without significant fraud reduction

And yet, there is that pesky problem of how to price the new product. In particular, Ontario auto insurers are vexed right now about how to price the product without knowing at least four key aspects of the reforms.

First, the Financial Services Commission of Ontario (FSCO), Ontario's insurance regulator, has made it a priority in 2010 to nail down a definition of what constitutes a 'catastrophic impairment.' The regulator has called for a panel of industry stakeholders to review and refine the definition, which is important to insurers, because anyone with a catastrophic injury arising from a motor vehicle collision is subject to a higher level of accident benefits ($1 million). That has a huge impact on an insurer's claims costs.

Second, also up in the air is the direction of the government's proposed new Minor Injury Guideline (MIG), which will determine the types of injuries that are subject to the $3,500 minor injury cap. The MIG is intended to replace the existing Pre-Approved Framework (PAF) Guideline for Grade I and II Whiplash Associated Disorders

Third, many insurers are trying to figure out whether cost savings on the AB side of the equation will be lost on the tort side, as lawyers pursue litigation to make up for what they can't secure for their clients in the form of accident benefits.

Finally, there is background uncertainty related to how consumers respond to their new options. Essentially, insurers will have to price the product without reference to any historical data about what the take-up rates of these options will be.

And so where pricing the auto product is concerned, over the next two years, Ontario auto insurers will essentially be thrust into the role of riverboat gamblers. Insurers and their actuaries will essentially be pricing the product with the same scientific rigor as a Mississippi riverboat gambler playing the roulette wheel, or betting the house on Lucky Number 7s.

"Until these [post-reform] claims start to close, and you get a broad-based perspective on the exposure on these claims, you have no idea [how to price]," said Steve Smith, president of the Farm Mutual Reinsurance Plan, echoing the views of many other insurers. "It's not like everybody else is going to be starting to reserve and handle their claims consistently, so there's no way as an industry... we are going to know for at least 24 months what the effect of the reforms will be. You're going to have people reserving conservatively. You're going to have them reserving optimistically. The early indications are easily going to be a guess at best."

Adds Cooke: "I don't want somebody out there thinking I have a negative tone [about the reforms]. I just think that anyone thinking that [the outcome] is anything other than uncertain is crazy."

ROOTS OF UNCERTAINTY

The Catastrophic Impairment Definition

It's commonly acknowledged insurers will not know how catastrophic impairment is to be defined until well after the Sept. 1, 2010 implementation date. Best guesses are that the province will take at least six to nine months to undertake its proposed review, with an outside time-line of one year.

The new definition is important. As Cooke points out, scientists who developed the definition of a catastrophic impairment currently in the Statutory Accident Benefits Schedule (SABS) never really intended the definition to be used to determine access to medical benefits in an auto accident. "They were developed as a preliminary screening technique so that medical people would know how to treat people who were suffering from a brain injury or a serious type of injury," Cooke said. "And we've effectively turned them into a padlock on a gate for benefit access. It really, I think, puts an inappropriate level of pressure on that guide and definition."

Insurers are concerned that recent court and arbitration decisions have mutated the definition in a way that makes it difficult to gauge how many consumers may be subject to a catastrophic injury determination. Such a determination expands an insurer's exposure multi-fold, since it entitles those with severe brain or spinal injuries to a much higher level of accident benefits than they would receive for more minor injuries. By the standard of the new reforms, it's the difference between a $50,000 non-catastrophic claim and a $1-million catastrophic claim.

Irene Bianchi, vice president of claims and corporate services at RSA, represented the view of many other insurers when she said she was "quite disappointed" not to see a real strengthening of the catastrophic impairment definition prior to the Sept. 1 implementation date. "Prior to this reform introduction, the cat definition had been significantly diluted, I think, from its original intention," she said. "We were starting to see a significant number of cat applications, a real jump from what we had seen over the past two or three years. That really is a huge, huge spend for insurance companies. When a lot of different types of claims are being deemed catastrophic, our exposure kind of goes through the roof."

Leonard Sharman of the Co-Operators General Insurance Company says the cat definition has been "diluted" by court and arbitration decisions that have deemed accident victims to be catastrophically impaired, even though their injuries come in below the 55% minimum threshold for a Whole Person Impairment and Mental and Behavioral Disorder. "With the reduction in standard benefits [from $100,000 to $50,000], we expect to see more applications for a determination of a catastrophic injury in the hopes that the impairments will meet the definition," Sharman said.

Cooke has a somewhat different take on the cat definition. He believes the industry, which has focused so much on tightening the cat definition over the past two decades, may in fact have got it backwards.

"I think we should have spent way more time defining what the minor injury actually is, and putting boundaries around it, and found a way to open the policy limits up to allow access for the more seriously injured people," he said. "The reason for that is two-fold: first of all, if you make a mistake by being too exclusive at the minor injury end, the chance of doing harm to somebody is much less. Let's say somebody with a WAD-II whiplash and lower back strain, which is a very common occurrence in an auto accident, ends up two physio or chiro treatments shy [of their full prescribed treatment, after their limits are used up]. That's $90, not the end of the world. But if by tinkering around with the cat definition, you end up actually [depriving], say, 250 people a year that deserve access to benefits in excess of whatever the lower limits are…those people are in a very awkward spot, because they're not going to have the kind of care that they need."

Cooke acknowledges his opinion may not represent the majority view of the industry, and it doesn't. But the government will be including these kinds of views, plus those of health care service providers, in its future deliberations. In the meantime, how is an insurer supposed to price a product for Sept. 1 without knowing exactly who is entitled to the higher limits?

It might be difficult, but it's not impossible, said James Russell, chief underwriting officer for Aviva Canada. "Typically, you like to see things play out and see how they cost, but you know we're not in that environment, so there's definitely uncertainty around [the cat definition]," said Russell. "But you have to make an estimate. You have to go with what you feel the intent is. It does appear that the intent is to have a robust definition in place and to put measures in place to make sure that the product is affordable. Sometimes you have to go by the intent, and that's the place for you to start."

The New Minor Injury Guideline

As part of its reform package, the government is establishing a new Minor Injury Guideline (MIG). Minor injuries falling within the guideline are subject to a benefits cap limit of $3,500. The MIG is nowhere near in place, and the creation of the new regime appears to be a long-term project for the government. A final, definitive version of the MIG is not expected until after years of consultation. In the meantime, the province is expected to release interim guidelines in June 2010, and these guidelines appear likely to look like a variation of the Pre-Approved Framework (PAF) guidelines now contained in the SABs. PAF guidelines cover whiplash and whiplash-associated injuries. Insurers are concerned that if the interim guidelines for the MIG closely resemble what is now contained in the PAF, not many claims will fall under the MIG's caps, since very few claims right now actually fall within the PAF guidelines.

"The MIG seems to resemble very closely the PAF," observes Ken Lindhardsen, vice president of claims operations for the Ontario, Western and Atlantic regions of Desjardins General Insurance Group. "The premise of the PAF, like the MIG, was that a majority of minor injuries — the intent was probably somewhere around 80% — would be treated in PAF. But our experience, and the

experience of other insurers, I'm sure, is that a significant portion of claims that we had anticipated to be covered under the PAF were not covered by the PAF. And that had to do with the fact that the PAF didn't explicitly include psychological issues. So there was an opportunity there, when psychological issues came into play, for those injuries to be moved outside the PAF. For us, it was a significantly lower portion than the 80% that ended up being treated within the PAF. And with the MIG, there still seem to be some issues that need to be addressed there in terms of whether those psychological issues will result in [minor injuries] being treated within the MIG or not. It is another X-factor or level of uncertainty for us in terms of what the overall impact is going to be."

Bianchi echoes Lindhardsen's remarks, putting a rather sobering number on RSA claims that fall outside the PAF. "[The reforms] cap a claim at $3,500 in Ontario now for all treatment and assessments," she says. "That doesn't really seem to be much different than our pre-approved framework guideline, the PAF. But unfortunately, in terms of our experience, we have less than 1.5% of all of our AB claims in that pre-approved framework. So okay, the big difference [between the proposed MIG and the PAF] is what? This is what we are struggling with. We're really not sure if we're going to see a lot of change, because so few of those claims now actually fit within that band."

How Will Trial Lawyers Respond?

As they struggle to place a price on the reforms, insurers are left to wonder whether any savings on the AB side will result in higher claims costs on the tort side. "We expect to see tort costs increase, but this was not considered in the reforms," Sharman said. "No tort costing exercise was done."

Insurers fully expect creative and inventive trial lawyers to attempt to obtain tort damage awards when they find the door of no-fault accident benefits closed to their clients. For example, given that AB benefit limits in the standard package have been reduced from $100,000 to $50,000, insurers fully expect trial lawyers to put additional pressure on the catastrophe definition and MIG guidelines.

"There's a lot of speculation that the AB is simply going to get transferred to the tort side," said Smith. "Right now, when you look at the cat determination rules, and minor injury rules, a lot is wide open to interpretation." And now that the standard benefits package is down to $50,000, he added: "Everybody is going to want to go cat determination."

Bianchi likens the relationship between no-fault accident benefits and tort costs to squeezing a balloon. "If you get rid of something on the one side, it's going to pop up on the other side," she said. "So we are expecting to see some more activity on the tort side. As plaintiffs are unable to collect on the accident benefits side, they will go to the tort side, if there is an opportunity to have a tort claim.

"Personal injury lawyers are an extremely creative and intelligent bunch. I take my hat off to them, because at every opportunity, whenever there's new legislation, they are quick to find the loopholes."

The 'X-Factor' of Consumer Choice

Consumer choice is central to the province's reforms. Widely praised by regulators, politicians and insurers alike, the element of consumer choice does add another, difficult dimension to pricing. Quite simply, Ontario's auto product has not offered choice before. And so insurers do not have a history of data indicating consumer preferences. Insurers don't know, for example, how many people will opt for the standard product, how many people will buy options. Without this information, insurance actuaries will have to guess how people will respond to the options from which they will have to choose starting on Sept. 1. "It's quite an actuarial challenge," Cooke said of pricing the reforms. "It's where the actuaries have to park some of their science and draw up a little bit of art, in terms of what they do."

Insurers are projecting a certain amount of guesswork will be involved when they file the first reform-related rate applications with the regulator. As soon as those approvals are announced, the marketplace will then be able to see what the various insurers have guessed in terms of pricing for the new product. Insurers will also be checking their rate requests against IBC data. Some cite the possibility that insurers will likely re-file rate requests before Sept. 1, making adjustments once they have looked to see how other companies have filed. "Will the whole industry price at the most optimistic level of reductions to start?" Russell said. "I can't really say that. I'm not sure that would happen, but you have to make an assumption based on what you feel is going to happen."

Post-Reform Pricing

Once the reforms are implemented, it will take awhile before insurers begin to notice trends in their claims litigation files. At the same time, they will be amassing data on how consumers are selecting their new insurance options. If the government committee comes up with a catastrophe impairment definition and an interim MIG by the end of the year, as projected, then all of the pieces of the pri
cing puzzle should start coming together. Insurers suggest post-reform pricing trends will start to manifest anytime between six and 24 months. Several said six months might be too optimistic; most thought two years would be a more realistic timeline for getting a sense of how effectively the reforms will control insurers' claims costs and thereby stabilize pricing.

By that time, it's quite possible the window of opportunity for costs savings will be closed. One potential dilemma of a "slow-drip" reform process, as one insurer characterizes it, is that the cost savings on the no-fault side may be sabotaged by higher claims costs on the tort side, or by lawyers' ability to get around the new accident benefits caps. It's one reason why some insurers are longing for a "CTL-ALT-DEL" approach to reform, as Baron Insurance Services Inc. president Barb Addie terms it in an article.