November 29, 2024

Financial Services Regulatory Authority of Ontario (FSRA)

RE: Consultation on Auto Reforms (ID: 2024-011)

This supplemental submission is being made by Lifemark Health Group (LHG) from the perspective of our Medical Assessment Division, where we operate under both the AssessMed and Viewpoint brands.

As background, LHG is a wholly Canadian-owned national healthcare provider, with over 25 years of service excellence providing unparalleled clinical and specialty rehabilitation services and delivering the highest level of patient care and outcomes. Across Canada, LHG has over 5,800 employees working at over 360 locations who facilitate over 4 million annual visits across community rehabilitation, workplace health and wellness and medical assessment services for customers across Canada, including the Property & Casualty (P&C) insurance industry.

We thank FSRA for the opportunity to share our perspectives on opportunities for auto insurance reform that are not already contemplated in the consultation papers, specifically on the topic of Insurer's Examinations (IE). Taking into consideration the principles that guided FSRA's review for this consultation, this submission focuses on improving the consumer experience, sustaining high-quality and timely access to care to drive improved patient outcomes, and supporting appropriate remuneration of highly skilled healthcare workers to ensure consumers continue to be able to access the expert care they deserve and require.

Summary of Recommendations

Specifically, LHG is recommending that FSRA:

1) Modernize the fee caps for IEs in ss. 25(5) and 42.2 of the Statutory Accident Benefits Schedule (SABS) and update rates in line with what is done for Health Service Professional rates.

2) Promote fairness and reduce instances of abuse associated with missed or cancelled IE appointments by aligning penalties with those applied in other non-auto insurance schemes.

3) Change the term Insurer's Examination to Independent Medical Examination (IME).

We are aware that these types of reforms require regulatory amendments to the SABS, which must be introduced by the Ministry of Finance (MOF). LHG strongly recommends that FSRA champion these reforms and advocate for the MOF to make overdue and meaningful regulatory amendments, where required. Proposed language is included for consideration in **Appendix A.**

Rationale

1) **Modernize fees for Insurer's Examinations**

As noted in LHG's previous submission for the auto insurance reforms consultation, LHG strongly supports the review of the fees and associated caps set out in the SABS, which have not been updated since 2010. Fair compensation for medical assessment vendors in the auto insurance system is crucial in promoting a sustainable and competitive sector, while ensuring the involvement of highly qualified medical assessors. Compensating assessors appropriately improves the quality and timeliness of assessment reports, enhancing the overall claims process for customers.

It is important that any update to rates and fee caps be inclusive of those outlined for IEs and occur in lockstep with changes for other health professionals that may be advanced through broad auto reform efforts.

In **Appendix B**, we have provided a recommended fee schedule for all commonly utilized medical assessment services for all insurers that balances the protection of consumer interests with the ability to foster a strong, sustainable and competitive insurance sector This schedule has been created using 2010 pricing (when the fee caps were established), compounded annually by 3.0% (for average inflation) to 2024. We would recommend that this schedule of fees continue to be updated annually and indexed to inflation.

To be clear, while we understand concerns may be raised regarding the impacts of increasing assessment rates on already high insurance premiums, **we do not believe that any increased costs should be passed on to consumers.** It is also worth noting the impacts to timely and high-quality access to care that have arisen because of the longstanding fee cap on assessment services. The low threshold of the fee cap in IMEs has resulted in many assessors prioritizing tort assessments (which do not have a fee cap). LHG would strongly support the removal of fee caps for IMEs in a modern and efficient auto insurance system.

2) **Promote fairness and reduce instances of abuse associated with missed or cancelled Insurer's Examinations (IE) appointments**

Health service providers face considerable challenges with injured auto insurance claimants who fail to show up to scheduled medical assessments, recording a consistent 25% no show/late cancellation rate over the last number of years – approximately 2.5 times the frequency of no show/late cancellations for other types of insurance claims outside of the SABS.

The high level of no show/late cancellations, for which claimants are not penalized like in other insurance benefits systems (i.e. no payment of retroactive benefits for missed appointments), means that many injured Ontarians who want to be assessed, access their benefits and commit to recovery often have their assessment times delayed. This issue also drives high unnecessary costs for the system at an estimated impact of around $20-30 million annually.

Overall, this high level of absenteeism warrants consideration of regulatory amendments to ss. 37, 42 and 44 of the SABS for no show and late cancellations fees. This would put auto insurance claims on a similar

footing to other sorts of disability claims, and accordingly, we are confident that no show/late cancellations rate for these cases would drop dramatically.

LHG also believes that insurers should be required to report no show/late cancellations and their associated costs into Health Claims for Auto Insurance (HCAI) so we can get a more accurate cost impact of absenteeism in the sector going forward.

3) **Change the term Insurer's Examination to Independent Medical Examination (IME).**

Currently when a claimant needs to be assessed for accident benefit entitlement, the insurer will request that the claimant attends an Insurers Examination (IE). Prior to 2010, an IE was referred to as an Independent Medical Examination (IME), which was associated with less perceived bias in the assessment process than what is generally experienced by the injured consumer today.

Simple language changes to Section 42 to return to use of IME terminology have the potential to increase trust in the assessment process, and in turn support better outcomes for injured consumers.

In closing, LHG commends FSRA for pursuing the reforms that are the focus of this consultation, and for welcoming additional feedback on other reforms to the auto insurance system that are greatly needed. Putting consumers first and supporting fairness and sustainability in a modern auto insurance system, ensures that claimants are protected and can access the benefits they need, when they need them, so they can be properly and effectively medically assessed after suffering an injury in an auto accident.

We would welcome the opportunity to discuss these challenges and recommended solutions in greater detail or provide additional information at the request of FSRA.

Once again, thank you for the opportunity to comment on these important reform efforts.

Sincerely,

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Appendix A

Proposed Amendment to O.Reg.34/10 (Statutory Accident Benefits Schedule)

***Text in Red are the proposed changes to the current SABS*

Determination of continuing entitlement to specified benefits

37. (7) If the insured person fails or refuses to comply with subsection 44 (9), the insurer shall,

(a) make a determination that the insured person is no longer entitled to the specified benefit; and

(b) refuse to pay specified benefits relating to the period after the insured person failed or refused to comply with that subsection and before the insured person complies with that subsection. O. Reg. 34/10, s. 37 (7).

(8) If the insured person subsequently complies with subsection 44 (9), the insurer shall,

(a) reconsider the insured person's entitlement to the specified benefit; and

(b) if the insurer determines that the insured person is still entitled to the specified benefit, the insurer shall resume payment of the specified benefit.

~~(ii) pay all amounts, if any, that were withheld during the period of non-compliance if the insured person provides not later than the 10th business day after the failure or refusal to comply, or as soon as practicable after that day, a reasonable explanation for not complying with that subsection. O. Reg. 34/10, s. 37 (8).~~

(8.1) (a) If an insured person provides, not later than the 10th business day after the failure or refusal to comply, a reasonable explanation for not complying with subsection 44(9), an insurer must reschedule the necessary Insurer Examination(s) required to determine ongoing benefit(s) entitlement, within 10 business days from the date that the claimant provided a reasonable explanation for non-compliance.

(b) An insurer is only obligated to reinstate payment for a specified benefit on the day after an insured person attends the rescheduled Insurers Examination.

(c) For greater clarity, if the insurer requires the insured person to attend multiple assessments to address different specified benefits, if deemed to be owing, the insurer will reinstate a specified benefit once the insured person attends the first scheduled assessment, however if the insured person fails to attend subsequent assessments, specified benefit payments can once again be stopped and the process in 8.1 (a) repeated.

Application for Attendant Care Benefits

42 (14) If an insured person fails or refuses to comply with subsection 44 (9), the insurer ~~may~~ shall,

(a) make a determination that the insured person is not entitled to attendant care benefits; and

(b) refuse to pay attendant care benefits relating to the period after the person failed or refused to comply with that subsection and before the insured person submits to the examination and provides the material required by that subsection.

(15) If an insured person subsequently complies with subsection 44 (9), the insurer shall,

(a) reconsider the application and make a determination under this section; and

(b) subject to the new determination, subsection 18 (3) and section 20, resume payment of attendant care benefits.~~; and~~

~~(c) pay all amounts, if any, that were withheld during the period of non-compliance, if the insured person provides, not later than the 10th business day after the failure or refusal to comply, or as soon as practicable after that day, a reasonable explanation for not complying with that subsection.~~

15.1 (a) If an insured person provides, not later than the 10th business day after the failure or refusal to comply, a reasonable explanation for not complying with subsection 44(9), an insurer may choose to pay all amounts, if any, that were withheld during the period of non-compliance.

(b) If an insured person provides, not later than the 10th business day after the failure or refusal to comply, a reasonable explanation for not complying with subsection 44(9), an insurer must reschedule the necessary Insurer Examination(s) required to determine ongoing benefit(s) entitlement, within 10 business days from the date that the claimant provided a reasonable explanation for non-compliance.

(c) an insurer is only obligated to reinstate payment for a specified benefit on the day after an insured person attends the rescheduled Insurers Examination.

(d) For greater clarity, if the insurer requires the insured person to attend multiple assessments to address different specified benefits, if deemed to be owing, the insurer will reinstate a specified benefit once the insured person attends the first scheduled assessment, however if the insured person fails to attend subsequent assessments, specified benefit payments can once again be stopped and the process in 8.1 (a) repeated.

Examination required by insurer

44. (9) The following rules apply in respect of the examination:

1. If the attendance of the insured person is not required, the insured person and the insurer shall, within five business days after the day the notice under subsection (5) is received by the insured person, provide to the person or persons conducting the examination such information and documents as are relevant or necessary for the review of the insured person's medical condition.

2. If the attendance of the insured person is required,

i. the insurer shall make reasonable efforts to schedule the examination for a day, time and location that are convenient for the insured person,

ii. the insured person and the insurer shall, not later than five business days before the day scheduled for the examination, provide to the person or persons conducting the examination such information and documents as are relevant or necessary for the review of the insured person's medical condition, and

iii. the insured person shall attend the examination and submit to all reasonable physical, psychological, mental and functional examinations requested by the person or persons conducting the examination.

3. If the examination relates to an application for attendant care benefits, the report of the examination must include an assessment of attendant care needs prepared in accordance with section 42. O. Reg. 34/10, s. 44 (9).

(10) (a) If an insured person provides, not later than the 10th business day after the failure or refusal to comply, a reasonable explanation for not complying with subsection 44(9), an insurer must reschedule the necessary Insurer Examination(s) required to determine ongoing benefit(s) entitlement, within 10 business days from the date that the claimant provided a reasonable explanation for non-compliance.

(b) An insurer is only obligated to reinstate payment for a specified benefit on the day after an insured person attends the rescheduled Insurers Examination.

(c) For greater clarity, if the insurer requires the insured person to attend multiple assessments to address different specified benefits, if deemed to be owing, the insurer will reinstate a specified benefit once the insured person attends the first scheduled assessment, however if the insured person fails to attend subsequent assessments, specified benefit payments can once again be stopped and the process in 8.1 (a) repeated.

COST OF EXAMINATIONS

25. (5) Despite any other provision of this Regulation, an insurer shall pay,

(a) the scheduled fees in accordance with the FSRA scheduled fee schedule as issued on an annual basis, plus the amount of any applicable harmonized sales tax payable under Part IX of the *Excise Tax Act (Canada)* for accidents that occur on or after October 1, 2024, in respect of fees and expenses for conducting any one assessment or examination.

(6) For the purpose of assisting the insurer with obtaining the most cost effective and timely assessments, it is permissible and encouraged that an assessor utilizes the administrative services of a Regulated Health Professional during the assessment process.

(6.1) For greater clarity, administrative services include

(i) completing a file review of all relevant documents as provided by the insurer and subsequently providing the primary assessor with a summary document of no more than 2 pages in length;

(ii) interviewing the examinee prior to the assessment to obtain relevant information to the impending assessor interview and/or examination; and

(iii) Reviewing or using intake forms to help collect pertinent details regarding the assessment.

(6.2) At no time can a Regulated Health Professional providing administrative services offer any medical opinions to the examinee or the primary assessor nor is it permissible for a Regulated Health Professional to draft any part of a medical report.

(6.3) For greater clarity, the primary assessor remains solely responsible for the development, review and content of all assessment reports. If a Regulated Health Professional is utilized within the assessment process, the identification of this individual and their respective credentials must be identified in all assessment reports submitted by the primary assessor and the fee charged by the primary assessor must incorporate the fee incurred to utilize the Regulated Health Professional in the capacity of an administrative assistant in the assessment process.

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Appendix B

Table 1: Fee Comparison & Proposed Fee Schedule Changes

Assessment Type*	2010 Average Fees	2024 Average Fees	Differential 2024 vs 2010	% Increase/ Decrease 2024 vs 2010	Modernized Fee Schedule 2025 (+HST)
Functional Abilities Evaluation	$ 800.00	$ 737.50	-$ 62.50	-7.8	**$ 1,210.07**
General Practitioner (GP)	$ 1,200.00	$ 1,125.00	-$ 75.00	-6.3	**$ 1,815.11**
Neurology	$ 1,450.00	$ 1,575.00	$ 125.00	8.6	**$ 2,193.26**
Neuropsychology	$ 1,750.00	$ 2,000.00	$ 250.00	14.3	**$ 2,647.03**
Ophthalmology	$ 1,800.00	$ 1,692.50	-$ 107.50	-6.0	**$ 2,722.66**
Orthopaedic Surgery	$ 1,375.00	$ 1,300.00	-$ 75.00	-5.5	**$ 2,079.81**
OT - In Home	$ 840.00	$ 837.50	-$ 2.50	-0.3	**$ 1,270.58**
Otolaryngology	$ 1,800.00	$ 1,692.50	-$ 107.50	-6.0	**$ 2,722.66**
Physical Medicine and Rehabilitation	$ 1,750.00	$ 1,600.00	-$ 150.00	-8.6	**$ 2,647.03**
Psychology	$ 1,600.00	$ 1,600.00	$ -	0.0	**$ 2,420.14**
Psychiatry	$ 1,800.00	$ 1,825.00	$ 25.00	1.4	**$ 2,722.66**
Vocational with Transferrable Skills Analysis (TSA)	$ 1,500.00	$ 1,450.00	-$ 50.00	-3.3	**$ 2,268.88**

** For illustrative purposes, the top 12 billed services have been provided. A full schedule of all service types, using the same methodology can be provided upon request.*

Additional notes:

- Since 2010, fees for all but three top 12 assessment services have either decreased or remained unchanged.
- Modernizing current assessment fees was calculated using 2010 pricing and compounded annually by 3% (for average inflation) to 2024; future year over year fee increases are recommended to be indexed at a 2% annual increase.
- Catastrophic assessments have long been completed at a financial loss and should not be scheduled the same as other assessment types noted above. Fees for Catastrophic assessments should be billable at market rate plus 25% administrative fee for the vendor to a maximum of $5000.00 per assessment plus HST.