REHAB FIRST
Building futures.

November 28, 2024

Mr. Peter Bethlenfalvy
Minister of Finance
7th Floor, Frost Building South
7 Queen's Park Crescent
Toronto, Ontario M7A 1Z5

Subject: Status of Auto Insurance Reforms

Dear Mr. Bethlenfalvy,

While we will give FSRA the benefit of the doubt that their intent is honorable concerning auto insurance reform, historically FSRA's track record has been poor when it comes to protecting injured accident victims and providing regulated health care providers with the resources that they need to perform their jobs. Auto insurance reform is long overdue.

We are writing to provide you with our perspective as a leading community-based rehabilitation health care service provider in the province of Ontario, regarding the current state of the auto insurance industry, the stewardship of the **Statutory Accident Benefits Schedule (SABS), and the proposed changes**.

By way of introduction, we will summarize for you a profile of our organization, Rehab First. We are one of Ontario's largest community-based rehabilitation health services providers. Although we assess and treat people who have been injured or experienced severe illness due to many different causes, much of our work has been with claimants who have been injured as a result of auto accidents, most of whose injuries would fit the definitions of "serious," or in auto insurance terminology "catastrophic".

This year, our more than 100 regulated health professionals (Occupational Therapists, Registered Nurses, Social Workers, Registered Psychotherapists, Physiotherapists, and Speech-Language Pathologists, etc.) will submit 7,500 treatment and assessment plans having a total value of almost $20 million, to most of the province's auto insurers. Our multi-disciplinary health care providers, assess, treat and care for, many people who have been injured, when they have been drivers, passengers, pedestrians or bicyclists, often through no fault of their own.

For several years, we have become concerned about a growing pattern of personal injury claims disservice to the 40,000-50,000 auto insurance product consumers who become claimants every year. Many of those claimants have struggled to access the health care they have purchased and now require, to meet their medical, rehabilitation, and attendant care needs.

We will do our best to outline our experience and perspective on our work with our clients, and to briefly provide our perspective on the proposed changes.

Enabling ConsumerChoice and Optional Benefits

Standard benefit policy limits for medical, rehabilitation and attendant care benefits need to be at a level sufficiently high to meet the needs of most, if not all, people injured in a motor vehicle accident. Suffice it to say that $65,000 in combined medical, rehabilitation and attendant care benefits for a seriously injured accident victim is simply not enough coverage. And, $1,000,000 of combined medical, rehabilitation and attendant care benefits for a catastrophically injured accident victim, especially those who are young and have many years of life ahead of them, during which they will have to deal with ongoing levels of disability and decreased function, is far from adequate. The standard policy limit of $1,000,000 insurance coverage for seriously or catastrophically injured accident victims for medical and rehabilitation benefits was provided to policyholders in the Province of Ontario more than 30 years ago. By today's standards, with inflationary pressures, the limits should be at least $2.5 million, and potentially more.

The concept of "buying up" optional benefits has not been well received or understood by the people of Ontario. Only approximately 10% of policy holders actually "buy optional benefits." If options are given to "adjust" benefit levels to a personally "desired" level, to "save premiums" then "buying down" should only be allowed for the policyholder, who freely gives their informed consent regarding benefit levels. All other innocent accident victims should be protected, with adequate levels of insurance coverage, especially when it comes to medical, rehabilitation and attendant care benefits.

Personally, we would not presume to "buy down" benefit levels for our loved ones, without their informed consent, lest they should unfortunately be injured in a motor vehicle accident. Policyholders or "drivers" should not be allowed to make this type of decision, to "buy down" for anyone but themselves.

FRSA needs to significantly increase the mandatory SABS policy limits for any seriously injured motor vehicle accident victim, and "buying down" should be limited to only policyholders who make informed decisions for themselves, not for others.

Medical, Rehabiltiation and Attendant Care Benefits,Duration and Limits

FSRA has previously cut back and decreased not only the policy limits, but the length of time an injured claimant can be eligible for medical, rehabilitation and attendant care benefits. Currently a serious (but non-catastrophically) injured claimant can access benefits for a 5 year period of time. However, for many seriously injured claimants the 5 year limitation, and the policy limits are often not adequate to meet their needs. While many accident victims can and do recover within the 5 year limits, many can have surgeries and other medical and care needs many years after an accident has occurred. Many accident victims are left to function with a lifetime of disability and need for significant levels of care, whether they are considered catastrophic, non-catastrophic or seriously injured.

The existing 5 year duration rule regarding treatment and care is arbitrary, does not meet the realistic needs of many people who have been injured and who are unable to reach maximal level of recovery within the 5 year time frame. FSRA needs to recognize that some seriously injured

accident victims will have need for care for years, and some even throughout the remainder of their life. The limits regarding duration need to be significantly lengthened, just as the financial limits need to be significantly increased.

Catastrophic Designation and Delays

For some clients who are seriously injured and need significant levels of treatment, care, assistive devices and modifications to the environments they function within, there can be a significant delay in the process to be "deemed catastrophic" to allow access to the higher levels of benefits the designation brings. For some claimants, this delay can be several months and even years. The appeal process to challenge a denial by an insurance adjuster, can not only take significant time, but can be costly and beyond the means and abilities of many injured people. Interruption of care and treatment while waiting for catastrophic determination, and even simple denial of a treatment plan, can cause not just delay in recovery, but potentially permanent harm. To help solve this problem, the "non-catastrophic" limits should be significantly increased, the "catastrophic determination process" should be much quicker and easier, as should the appeal process when an adjuster may have erred.

Attendant Care Benefits

The attendant care benefit rates setout on the Form 1, are below the level of minimum wage and are not workable for people with disabilities or attendant care providers. Realistically, a claimant who is in need of attendant care will require a benefit level sufficiently high enough to allow purchase of attendant care services from a qualified provider, at an appropriate market rate.

In the insurance and health care communities a claimant must incur an "economic loss" in order to justify an attendant care expense. Personally, we believe that is good practice and that the benefit should be provided, when and if the need is being met. However, seriously injured claimants must be provided with benefits at an adequate rate to hire an attendant care provider. The monthly and lifetime policy limits for attendant care benefits must be set at a level that will meet the care needs of both serious and catastrophically injured claimants.

For injured claimants who require 24 hour per day, 7 day per week attendant care, the costs are significant for both insurers and claimants. Claimants, insurers and health care providers, need to work together to find safe, workable solutions that meet the needs of people injured, and their families. When FSRA previously scaled back and significantly reduced attendant care (and medical and rehabilitation) benefit levels, they caused significant harm to many innocent, injured accident victims. Attendant care rates also need to keep up with the cost of inflation.

Priority of Payment and Supplementary Group Health Insurance Plans

The current SABS requires a claimant to access any supplementary health insurance plan that they have access to, as first payer, for their medical and rehabilitation treatment. Auto insurers are actually "second payers" for medical and rehabilitation costs under the current system. Consequently, the requirement to submit claim forms, and to collect payment after provision of medical and rehabilitation assessments or treatments from group insurers first, and auto insurers

second, has been downloaded onto health care providers and the clinics that they work for, even when OCF 18s (assessment and treatment plans) have been approved and delivered. Many if not most health care providers are ill equipped to handle this burdensome administrative claims process, and cannot afford to retain administrative staff to help injured accident victims with this claim submission and collection process.

While FSRA's policies are that health care providers need make only "reasonable" efforts to facilitate the group health care claim submission and administration, many auto insurance adjusters have used this complicated collection procedure to not only delay payment of healthcare claims, but to deny treatment to clients, and to withhold approval of proposed assessments and treatments. That type of adjuster practice is simply unacceptable. While the requirement for supplementary group health insurance claim submission may be meeting the needs of insurers, to help reduce the costs of health care claims, and to help keep auto insurance premiums low, it does not work for many injured claimants, especially for those with cognitive or psychological issues after injury. The process does not work for health care providers who are often left in the middle to try to sort out the administrative mess between insurers for services that have been "approved by insurers" and "delivered by licensed and regulated health care providers."

If auto insurers want to retain group insurers as first payers for medical and rehabilitation benefits, then the process should be simplified. Auto insurance adjusters could take responsibility for coordinating payments with the group insurer (and group insurers could be required or strongly encouraged to comply by FSRA), and health care providers should be relieved of this unnecessary administrative and financial burden.

Rectifying this administrative nightmare, as the government has indicated they intend, should make the system more efficient, save costs, and could help to ensure injured accident victims receive the treatments they need, in a timely manner, to promote and enhance their recovery. If FSRA follows through on their intention to make auto insurers first payers for medical, rehabilitation and attendant care benefits, this change would be positive and helpful, would save costs for healthcare providers, could improve access to treatment and enhance recovery for claimants.

Professional Services Guideline / Provider Fees

There is another area of neglect that has need for attention under the reform agenda. We are referring to the fee schedule to which we are subject to as providers of regulated health care services and social workers are compensated at for our work under the SABS. The fee schedule for health care providers was previously updated periodically, but it has not been updated now in more than ten years. The fee schedule was last adjusted in September 2014. It has been significantly eroded by time and inflation.

Below, we have provided you an image of the FSCO/FSRA document that governs fees called the Professional Services Guideline, and the Guideline's fee table.

Fee Table Contained in the Guideline Document

APPENDIX – REVISED RATES AND FEES

Health Care Profession or Provider	Maximum Hourly Rate *except catastrophic impairments*	Maximum Hourly Rate *catastrophic impairments**
Chiropractors	$112.81	$135.36
Massage Therapists	$58.19	$89.07
Occupational Therapists	$99.75	$119.92
Physiotherapists	$99.75	$119.92
Podiatrists	$99.75	$119.92
Psychologists and Psychological Associates	$149.61	$179.29
Speech Language Pathologists	$112.22	$134.17
Registered Nurses, Registered Practical Nurses and Nurse Practitioners	$91.43	$109.24
Kinesiologists	$58.19	$89.07
Unregulated Providers		
Case Managers	$58.19	$89.07
Family Counsellors	$58.19	$89.07
Psychometrists	$58.19	$89.07
Rehabilitation Counsellors	$58.19	$89.07
Vocational Counsellors	$58.19	$89.07

*This rate applies to all services rendered on or after September 6, 2014 to an insured person whose impairment is determined to be a catastrophic impairment as defined in the SABS whether such services are rendered before or after such determination is made.

Form	Maximum Payable for Completion of Form
Disability Certificate (OCF-3)	$200.00
Treatment and Assessment Plan (OCF–18)	$200.00
Automobile Insurance Standard Invoice (OCF-21)	$0.00

As health care providers, we feel that we have made more than our fair contribution to the stabilization of the financial health of the auto insurance industry; this, in addition to the steady stream of benefit cut-backs instituted under the guise of “reform” over the years, and the policy limits that were established some 30 years ago, has demonstrated that FSRA’s priorities have not been innocent, injured accident victims, or health care providers.

Injury benefits, including income replacement benefits as well as medical, rehabilitation and attendant care benefits, and costs for insurers to assess a claimant’s entitlement to a benefit, account for less than 50% of all auto insurance claim costs. With the pressure on insurers to reduce premiums being as intense as it was, it was perhaps understandable why everyone had to make their share of sacrifices, but is a fee freeze that has extended more than ten years now really the way to do it? Fees paid to health service providers are certainly part of the cost equation, but are really only a small portion of the premium and expense dilemma.

Our mission in our professional lives has been to help people recover, not to indirectly fund insurer bottom lines, or to improve what are, incontestably, much improved loss ratios. Our team of health care providers at Rehab First has been dedicated to helping people recover, if possible, from their often traumatic injuries and to continue with their lives.

While some health care providers have chosen to work with other populations, rather than people injured in automobile accidents, thankfully some of us have remained committed to providing care and helping people recover from their injuries. However, our health care providers need to be compensated at fair and adequate rates of pay for the effort, skill and the dedication that they bring to their work. If they are not, we fear many more will leave this type of work, and people injured in auto accidents will experience even more difficulty accessing care.

It is generally accepted in the industry that actuaries have been provisioning for health care fee increases in their reserves as a regulatory contingency every year for the past 10 years. In other words, they have already planned for and expensed reserves for fee increases, and impounded ongoing funding of those increases in their rate filings. Insurers have benefitted from the service provider rate freeze, at significant cost to health care service providers, and injured accident victims.

The Professional Service Guideline fee schedule is out of step with prevailing "open market" fees for the professions it covers, making it increasingly difficult for health care companies to compete with government-funded agencies such as hospitals, whose compensation levels have generally increased with the CPI.

If FSRA were to adjust the 2014 fee schedule, referencing a relevant benchmark (i.e. increases in Ontario's average wage for health care workers up to 2024), this is how the table would look:

***Pro Forma* Rate Table-Adjusted by Avg. Wage-Health-Ontario-2014-2024**		
Health Care Profession or Provider	**Maximum Hourly Rate *except catastrophic impairments***	**Maximum Hourly Rate *catastrophic impairments****
Chiropractors	$145.52	$162.40
Massage Therapists	$75.07	$114.91
Occupational Therapists	$128.68	$154.71
Physiotherapists	$128.68	$154.71
Podiatrists	$128.68	$154.71
Psychologists and Psychological Associates	$193.00	$215.10
Speech Language Pathologists	$144.78	$173.09
Registered Nurses, Registered Practical Nurses and Nurse Practitioners	$117.94	$140.93
Kinesiologists	$75.07	$114.91
Unregulated Providers		
Case Managers	$75.07	$114.91
Family Counsellors	$75.07	$114.91
Psychometrists	$75.07	$114.91
Rehabilitation Counsellors	$75.07	$114.91
Vocational Counsellors	$75.07	$114.91

As a practical matter, a seasoned Occupational Therapist who has been exclusively dedicated to auto injury clients since 2014, and who is responsible for a patient load weighted 80%/20% non-catastrophic/catastrophic, has experienced a cumulative loss of income of more than $68,000 during the 2014-2024 period.

Our recommendations for the fee guideline would additionally be as follows:

i) Registered Psychotherapists should be included at the same rate as Psychologists and Psychological Associates;
ii) Registered Nurses, Nurse Practitioners and Registered Kinesiologists should be at rates similar to Occupational Therapists and Physiotherapists.

Additionally, we strongly recommend that all "regulated" health care professionals who belong to and are governed by health care Colleges established through the Regulated Health Care Professionals Act, should be deemed to be "health care practitioners," for the purpose of completing OCF (Ontario Claim Forms) and submitting assessment and treatment plans for approval. The distinction between "practitioners" and "professionals" is arbitrary, not effective or useful, and adds an unnecessary extra layer of administrative bureaucracy and cost to the system.

Additionally the "Maximum Payable for Completion of Form" for a Disability Certificate (OCF-3) and Treatment and Assessment Plan (OCF-18) was set several years prior to 2014 and has not been increased since. The work required for the $200 fee requires far more than "simply filling out an administrative form." Medical history and information must be gathered, opinions rendered, information discussed and reviewed with clients, and informed consent must be obtained. It typically requires an assessment, in order to request funding to perform an assessment or treatment. These forms, while necessary and helpful, require a significant level of input and work by health care providers and administrators, to perform them properly and for healthcare providers to fulfill their ethical, regulatory and legal obligations. Payment for the work is only made by insurers, when an OCF-18 is approved or partially approved by an adjuster, but is not paid, when not approved, even if health care providers have done significant levels of work to assess a claimant and provide information. If additional information must be provided, to collegially help clarify circumstances for the many adjusters that we work with, or to try to help claimants get the care that they require, additional time to deal with the form and request is not compensated and adds to the administrative and financial burden of health care providers and health care companies. The fees provided for this process, need to be adjusted, at minimum to keep up with the increase in the CPI, and to more accurately reflect the amount of time and effort expended. The fee should be set and paid out by the insurers at the set fee, not at an arbitrary lower amount that some adjusters unilaterally determine and adjust.

If you would like further information from us on any of the issues that we have commented on, we would be more than willing to provide it. However, the decrease in the policy limits, the erosion of benefit levels (i.e. limits for medical, rehabilitation and attendant care benefits) and service provider rates, due to cut backs, inflation and time (i.e. since September 2014), are key factors that have historically been neglected by FSRA and need to be rectified as soon as possible.

Auto insurance reform is long overdue, and should be addressed quickly, to meet the needs of injured accident victims, health care providers, and the people of Ontario.

We are available at any time to elaborate or discuss this letter's contents.

Sincerely,

James Campbell
Registered Psychotherapist, M.Ed., MBA, CCRC, RRP, CCLCP, CVRP (F)
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Joanne Gram, M. Ed., OCT, RRP, CCRC, CCLCP, CVRP (F)
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cc: Mr. Glen Padassery, Executive Vice President, Policy and Auto / Insurance Product

APPENDIX A

February 2018 Auto Insurance Reform Submission to Minister Fedeli and Mr. Downey

Date: February 14, 2019

The Honorable Mr. Victor Fedeli, Minister of Finance
Mr. Doug Downey, Parliamentary Assistant

C/o Ministry of Finance
7th Floor, Frost Building South
7 Queen's Park Crescent
Toronto, Ontario M7A

Subject: Auto Insurance Affordability and Accessibility Strategies

Dear Misters Fedeli and Downey,

We are responding to the Ministry's request for feedback in its quest to make auto insurance more accessible and affordable.

As you know, auto insurance in Ontario is segmented according to nine lines of coverage. Our submission will focus on the two lines which represent the largest percentage of claim costs, they being the **Statutory Accident Benefit** and **Third Party Liability-Personal Injury** lines. In the 2015, 2016 and 2017 calendar years, according to FSCO, those lines accounted for 58.1%, 56.2% and 52.4%, respectively, of auto insurance claims costs.

What could be better aligned with the government's policy making and regulatory function than having an efficient, equitable public/private system that gives insureds access to funding for the medical, rehabilitation and in-home care services that they require, supports them in their return to employment, educational or domestic environments and whose entry costs for insurers are low? Why then, have premiums been so high and the claiming experience for AB medical/rehabilitation care, so poor for so many?

By way of partial response, I note that past attempts at reform have largely been at the instigation of the insurance industry. In 2016, for instance, the IBC declared on its web site that:

"Changes that took effect on June 1, 2016 make your Ontario auto insurance premium more affordable and give you more choice."

By early January of this year, one could say that the IBC's position had evolved, to the point where senior spokesman Peter Karageorgis was quoted by The Star as saying:

> ***"We haven't really had a government that's said, 'okay, let's take off the Band-Aid and fix the root cause of the problem.'"***

Karageorgis does not hint at what the "root cause" might be. He does go on to advocate a system "overhaul", however. If this is the IBC's admission that it is out of solutions, then the solutions must for the first time depart from an expert understanding of the problems. It is to this understanding, and therefore the identification of feasible, sustainable solutions, that we dedicate ourselves in this letter.

Our Credentials

Rehab first is a long standing multi-disciplinary health services provider specializing in the assessment and treatment of individuals with serious physical, psychological and cognitive impairments caused by injury and illness. Our professional staffing complement numbers approximately eighty and covers most of the major health disciplines, such as Occupational Therapy, Physiotherapy, Nursing, Social Work, Psychotherapy, Kinesiology and Speech-Language Pathology. Specialized practice areas include Case Management, Life Care Planning, Future Care Cost Reporting, and Personal and Family Counselling. We also have contractual relationships with over 100 Physicians and Psychologists through our **Med *Net*®** network, and we are a FSCO-licensed Provider Business whose motor vehicle injury clients over the years exceed ten thousand. In addition to having clients who self-refer, we have referral relationships with insurers, personal injury lawyers, hospital discharge professionals, and physicians, employers and workers compensation boards.

Over a thirty-year period I have personally witnessed the changes brought about by the Ontario Motorist Protection Plan (introduced in 1990), Bill 164 (automobile insurance reform implemented in 1994), Bill 59 (introduced in 1996) and Bill 198/5 (further reforms introduced in 2003), have worked during and after the DAC (Designated Assessment Centre) period, and led our company through the September 2010 and June 2016 reforms.

We have been active industry participants, having attended the 2015 and 2016 CTI (Common Traffic Injury) Guideline consultations at FSCO's Yonge Street offices, during which we suggested a method to cost the Guideline's care "pathways" as a basis for the setting of both overall and internal funding maxima. The suggestion was followed up by Finance for further particulars, which we then provided to it. We were one of the few early adopters of the IBC-developed and managed HCAI (Health Claims for Auto Insurance) system when it first launched in 2007. As you may know, the Superintendent instructed the IBC to shut the system down within a few months of launch when it became obvious that it was malfunctioning for insurers, health providers and claimants. One of us was subsequently consulted by HCAI project leadership during the 2008-9 remediation periods for advice to help ensure a successful re-launch in 2010.

Ralph Palumbo, a former IBC Vice President, and Mr. Karageorgis himself, have been speakers at our breakfast seminars, and in 2017 we submitted our views about the Marshall Report to Mr. Fedeli's predecessor, Mr. Souza. Our executive group includes individuals whose prior experience includes P&L responsibility for auto, health and disability insurance operations, as well as health and disability benefits consulting.

We bring an informed perspective to the affordability and accessibility dialogue.

Past Approaches to Premium Reduction and Accessibility

We thought it would be helpful to provide you with a summary listing of specific changes to date. Although they vary in their details, they have had a consistent cost reduction impetus:

1. Radically reducing benefit maximums (from $100,000 to $50,00 in 2010; then again in 2016)
2. Shifting the cost of former standard maximums to new optional coverages at an additional premium (2010; re-formulated in 2016)
3. Introducing a maximum of $2,000 on the cost of assessments
4. Reducing attendant care and income replacement benefits
5. Re-classifying approximately 75% of injuries as "minor" and subjecting them to a maximum that was less than 10% of the former maximum (from $100,000 to $3,500)
6. Tightening the qualification criteria for Catastrophic Injury benefits
7. Eliminating housekeeping, home maintenance and care giving benefits for all but the catastrophically injured
8. Freezing health provider compensation at January 2014 levels, which in real terms translates into a 10-15% reduction in the cost of provider services
9. Introducing a basic, centralized claim filing system (HCAI: launched 2007; re-launched 2009), the objective being to improve insurer efficiencies
10. Reducing the role of plaintiff personal injury lawyers in claim disputes
11. Proposing a new detailed benefit guideline for "Common Traffic Injuries", without costing the Guideline's prescribed services, then shelving the Guideline
12. Rate reduction enforcement, which even after the "Stabilization" reforms of August 2013, has had little effect, a contention supported by our reading of the technical filing guide developed for insurers, which allows unrealistic profit and expense charges, and perpetuates cost-plus industry pricing behaviors. This had been alluded to by the Auditor General in his 2011 review of auto insurance regulatory oversight, and indirectly by Mr. Marshall in his report

Reforms have clearly been one-sided, yet without the intended results being achieved, which leads us to conclude that Ontario's 90+ auto insurers may be challenged at:

- Managing their claims operations efficiently
- Quality assurance, as it relates to claim adjudication and administration, given the disparity of adjudication decisions, and the incidence of willful non-compliance with the Regulations. That a high percentage of AB claims are not paid by the insurers themselves, but are outsourced, likely compounds this problem.

- Fraud management. Fraud, though a problem, is in our view less an issue than the industry claims; it is simply a way to distract government from operating disciplines they should be managing to better align with the government's affordability priority, they being:
  a. Administrative efficiency
  b. Claim process and cost management
  c. Pricing methodology. As alluded to earlier, current systemic cost-plus pricing is irreconcilable with affordability when (a) and (b) are poorly managed, and is compounded by inflated reserving and expense and profit factors. By way of comparison, group health (drugs, treatments by Physiotherapists and other regulated health professionals, dental, out of Canada medical etc.) insurers commonly have far lower expense and profit charges for plans whose annual cash claims are as low as $1,000,000/year, and arguably, their fraud prevention methods are more advanced than auto insurers'. We also note, by the way, that the Auditor General took issue with the way FSCO was reviewing and approving rate filings.

Consequences for Claimants

Why you might ask, are we, a health services provider, delving into the murky topic of auto insurer operations? The simple answer is because the measures taken to reach this elusive goal of insurance affordability is hurting injured people. The many cut-backs, deletions and reductions have been detrimental to a significant percentage of our clients. Although with professional help, most injured parties recover lost cognitive and physical function, in a large number of cases these are people who have had the world fall out from under them when they were injured in their collisions. Either because of their physical and/or cognitive impairments, or the emotional trauma they have suffered, they have been rendered voiceless and unable to advocate on their own behalf. There are thousands of them, but you will only hear from a handful of them because neither they nor their families have the energy to fight denials of legitimate claims, and lawyers are taking far fewer cases because the reforms have deterred them from doing so.

Furthermore, the optional coverage that insurers have been required to offer since September 2010 as an accessibility consolation, has not been well promoted, with the result that policyholders who would have purchased it if it had been properly sold, are now running out of benefits for serious injuries. Our estimate, based on our own AB referral tracking, is that after being available for more than eight years, fewer than 5% of policyholders have optional benefits.

Where has all of this supposedly freed up system money gone? Claimants do not understand why a perfectly reasonable course of treatment, prepared and explained to them by a regulated health professional, and to which they have given their signed consent on the regulator's standard claim form, is denied or partially denied in 25% of cases (Mr. Marshall validates this statistic in his report); this after waiting up to ten business days or longer for the adjuster's decision.

If we were to tell you the stories about the types of adjuster behaviours that we as health providers have to put up with on a large number of perfectly reasonable treatment approval requests, you would think we were fabricating them. If we were to tell you that in a significant number of cases, insurers **deny us payment** for services they had **approved in advance**, and

that we had then gone on to perform with the client's consent, you might dismiss it as a fabrication as well.

We do not want to be viewed as industry or regulator critics. Insurers have a difficult job and our perception is that most of their adjusters are well-intentioned, caring people. Similarly, we know from our work in other sectors that FSCO, since its inception over twenty years ago, has had an impossibly large number of regulatory mandates. Indeed, at our well-attended breakfast seminar in October 2014, we wondered aloud if the time had come for a FSRA-like transformation.

In the interests of moving forward, we will turn the page figuratively and literally here and focus on our solutions, because we believe they have system-wide application and know that in some respects, they are common practice in other insurance sub-sectors. As such, they hold the promise of managing premium levels, while improving access and service to claimants at the same time.

Solutions

1. Encourage auto makers to make the accident avoidance features that are so common on upscale vehicles, standard equipment on all new vehicles. We need to continue to make both the roads, and vehicles that travel on public roads, safer.
2. Avoid imposing further benefit reductions. If they are going to be imposed, then in the interests of full disclosure, the cost shifting to OHIP and other government-funded social service programs should also be quantified to show their net financial impact to Ontarians.
3. Give those "minor injury" claimants mentioned in "Approaches….." item (5) above access to the statutory additional benefits available to them beyond the current $3,500 maximum (which in effect is being administered as a $2,200 maximum, by the way) without the current costly, adversarial process that benefits no one, and no doubt shifts costs to the MOHLTC of untreated injuries presenting themselves at emergency departments.
4. Restore former benefits maximums for the catastrophically-injured to pre-June 2016 levels. Given the restrictive qualification criteria governing claim approvals for these individuals, by definition most of them have undisputed life-long medical, rehabilitation, personal care and vocational needs. Many have devastating brain injuries and some are paralyzed. Even David Marshall drew attention to the plight of these individuals in his report.
5. The rate setting mechanism MUST change from being cost-plus-based to target-based. The current process perpetuates premium rate inflation, and we dare say, indirectly allows insurers to profit from fraudulent claims, even as they purportedly fight fraud at the same time. Further, it is ludicrous to allow the same 25% expense charges and 5% profit charges, as a percentage of premiums, for an insurer having 10% market share as for one having 1%.
6. Centralize the full claim processing and adjudication function in a way that makes decisions binding on insurers. This will ensure that greater consistency is achieved, claim cost projections more reliable and system-wide administrative costs lower. Let the IBC administer this operation; it is time that HCAI became more than a simple claim filing

engine. Marshall also proposed a centralized system, but our system would be the better one because unlike his, it would not burden hospitals or physicians.

We are available at any time to elaborate or comment further on any of this letter's contents.

Sincerely,

James Campbell
Registered Psychotherapist, M.Ed., MBA, CCRC, RRP, CCLCP, CVRP (F)
President and Co-Founder

APPENDIX B

January 2020 Technical Advisory Committee Application Submitted to FSRA

January 15, 2020

Ms. Sabrina Dias
Project Assistant
Auto Insurance Products
Financial Services Regulatory Authority
5160 Yonge Street
North York, ON
M2N 6L9

Auto Insurance Rate Regulation Technical Advisory Committee Membership

Dear Ms. Dias,

This letter and my resume together form my submission for consideration as a member of the Technical Advisory Committee.

My name is being put forward by Rehab First after having reviewed the Committee's mandate, its member qualifications and other terms of reference, in light of my areas of expertise and our organization's constructive participation in the regulatory dialogue over the years and in specific FSCO/FSRA and IBC initiatives.

My personal belief that I can make a significant practical contribution to the transformation of the rate setting mechanism stems from senior roles in two regulated insurance environments, they being auto insurance and life and health insurance (health, dental, travel accident, disability), as well as in the pension consulting industry, where I was responsible for fifty professionals, inclusive of the Actuarial and Pension Administration practices.

My sensitivity to the consumer aspects of auto insurance pricing decisions is informed primarily by my senior roles at Rehab First dating back to 2005, during which I have witnessed a number of changes to the auto insurance legislation and its prescribed benefits under the SABS, the regulations and guidelines that emanate from the SABS, and changes to the dispute resolution mechanisms. All of them, in one way or another, have required changes to our Rehab First operational processes, and given the effective freezing of provider compensation since 2014, and the reduction of benefits owing to the 15% premium reduction target, have required us to do so more efficiently, while maintaining our highly regarded quality standards.

Further on in this letter I elaborate on my direct experience with insurance pricing at a technical level, and my familiarity with the actuarial and regulatory aspects of auto insurance pricing in Ontario.

Rehab First and My Role There

Further to my foregoing comments, Rehab First is one of the injury and illness rehabilitation sector's largest provider organizations, giving us uncommon, if not unique, global and local insight into the needs of claimants as consumers. Our 100+ health professionals, which include Occupational Therapists, Psychotherapists, Physiotherapists, Registered Nurses, Case Managers, Social Workers, Life Care Planners and Kinesiologists, are located throughout the province. Indeed, we submit OCF-18s to most if not all of Ontario's auto insurers on behalf of our clients, their submitted value exceeding $10 million in 2009.

With respect to my role, I will touch on the more relevant pricing, process, development and industry outreach aspects. I note here that one of my responsibilities as Vice President, Case Support Services, is the pricing of all of our services, both regulated and unregulated, and the authoring procedures that ensure our compliance with FSCO/FSRA regulations, guidelines and bulletins.

I spearheaded our organization's early adoption of the IBC-managed HCAI system when it launched in 2007. Our relations with the HCAI support team were highly constructive. Shortly after our Rehab First HCAI implementation early in 2007, for example, we made a detailed recommendation to the HCAI team that was designed to streamline the registration of providers. Our recommendation was ultimately adopted as a change in HCAI standard procedure, thus removing a system-wide OCF processing obstacle. HCAI, regrettably, but understandably, was shut down by the Superintendent soon after launch. I was asked by the IBC (Gerry Dornan, HCAI's Project Manager) to advise on strategies for its successful re-launch.

IMEs being part of our multi-disciplinary model, I developed and launched Rehab First's **Med*NET*®** roster of contracted medical and psychological professionals, and I manage the company's relationships with the WSIB and CPP, with which it has Program of Care Expert Line and Vocational Rehabilitation service agreements, respectively.

Given my external relations responsibilities, elsewhere in this letter I will list examples of our organization's participation in regulatory initiatives and the submissions that we have made.

Previous Relevant Roles

In my senior roles at Crown Life, London Life, Aetna and latterly, Cowan Actuarial, Benefits and Pension Consulting, where I was Vice President and Waterloo office head, I have been responsible for insurance product (pooled, non-pooled and ASO), and consulting services pricing, respectively. I have managed Life, Health, Dental, Drug (both conventional and pay direct) products, as well as the benefits administration product line at two insurers. I have also been responsible for a Notice of Loss policyholder reporting line outsourced to us by one of Canada's largest P&C insurers.

With respect to the operational aspects of insurance pricing, I have been project lead for the re-design, development and launch of a group insurance rating/quote/renewal system. Pricing

automation, which required the improvement of real-time claims data access and access to actuarial formulas, was one of the key deliverables.

Contributions

In recent history I have been a key contributor to Rehab First's formal submissions to FSCO/FSRA or Finance in response to the following:

- **Call for submissions for Superintendent's priorities**
- **Call for submissions for Superintendent's three-year auto insurance review**
- **David Marshall's report**
- **The current auto insurance review.** Our detailed, fact-based letter was addressed directly to Misters Fedeli and Downey at the address provided to us by Finance. Among our recommendations were:

    1. the restoration of the Catastrophic injury maximum to its pre-June 2016 level
    2. changes to the rate filing and approval process.

    Although we would not have been the only parties making those recommendations, it is noteworthy that both are being pursued. We also recommended the centralization of the claims adjudication function, reasoning that it will be a challenge for 90+ auto insurers and their independent adjusters to align with any proposed standardized, efficient claiming processes as an expense factor reduction strategy. The failed attempt at launching HCAI in 2007, respectfully stated, may have been evidence of the merits of that contention.

I attended two **FSCO CTI Guideline** consultations, after which my offer to provide information about how Finance might cost the care pathways on which the Guideline was based was taken up, and the information then provided.

I was an industry representative on former Superintendent Laurie Savage's creditor insurance review committee, and shortly thereafter, the CLHIA's (Canadian Life and Health Association) creditor insurance committee to devise best approaches to complying with the Superintendent's requirements.

Other Technical Knowledge

With respect to technical matters, I have co-written underwriting, funding and administration manuals for large sponsored benefits plans, priced Actuarial pension consulting (plan design and amendment; investment strategy) and compliance (solvency and funding valuations, accounting basis reporting, and plan document, SIP&P and other statutory filings) services.

As noted earlier, and of relevance with respect to the potential administrative implications of transformational rating strategies is that I am a Lean and Six Sigma practitioner and have structured approaches to implementing the LeanSixSigma quality (i.e. "defects" reduction in Six Sigma parlance) and efficiency (i.e. "waste reduction" in Lean parlance) methods in the hospital,

local health, municipal, insurance and construction sectors. I would therefore bring expert insight into the feasibility of prospectively "pricing in"- in an actuarial sense- any required administrative cost and claim cost gains that are predicated on the adoption of industry-wide process improvements. Further to that point, I have consulted to Canada's largest retail IT group on architecture planning methods, so have an appreciation for the change management implications of "operationalizing" standardized processes across so many insurers.

I have investment side experience as well. As chairperson of a prominent institutional fund's investment committee, on which I served for ten years, I led the review of policies and procedures and our investment manager search during the worst of the financial crisis.

My article, **Employee Life and Health Trusts: Legal Construct or Innovation Catalyst?** (Pension and Benefits Monitor, 2012; print circulation of 20,000+). was one of the very first such articles to be published on the topic of ELHTs. As a Division G, Section.141.1 addition to the Income Tax Act in 2010, ELHTs were big news in the group insurance industry because of their transformational potential. A number of ELHTs have since been established, including the one for the Elementary Teachers Federation of Ontario's benefits plan.

I am familiar with the current rate filing and approval mechanisms at a technical level.

Consumer Research

The terms of reference make mention of consumer research.

Being an accomplished B2B and B2C market researcher, and having overseen the testing of pre-launch service prototypes, I will not pre-empt the results of surveys that may be undertaken under the auspices of the Committee. Yet, having served the physical, cognitive and vocational needs of tens of thousands of claimants over the years, a period that has witnessed a number of regulatory changes, we do have insights into what consumers value most, whether it is a "top-of-mind" articulation of value or one that would be anticipated to be top-of-mind were they and their families to suffer the consequences of a serious motor vehicle collision.

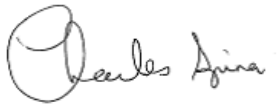
There appears to be an absence of "actionable" consumer intelligence, which itself may explain the poor uptake of optional auto insurance personal injury benefits since they were first made available in September 2010, and then re-structured in June 2016. Optional benefits, as you may know, are a self-funded, reasonably priced way for consumers to avoid financial hardship in the event of serious or catastrophic injury. The lack of adoption is both an opportunity cost to consumers-that is greatly magnified after an injury occurs-yet a hidden source of political capital for government.

Education

My formal education was received at the University of Ottawa (M.A. History), and UWO (Ivey MBA).

My style is collegial, constructive and participatory. I am available at any time to elaborate further on any aspects of my submission at your convenience.

Sincerely,



Charles Spina
Vice President, Case Support Services

APPENDIX C

June 2020 Letter to Minister Philips from Greg More and Charles Spina

June 17, 2020

Mr. Rod Phillips
Minister of Finance
7th Floor, Frost Building South
7 Queen's Park Crescent
Toronto, Ontario M7A 1Z5

Subject: Auto Insurance Reforms In Light of Industry COVID-19 Response

Dear Mr. Phillips,

Thank you for your continued leadership when leadership has mattered most. I can assure you that when planning for the resumption of our in-person health services to our patients, your government's many directives, especially the ones issued for regulated health professionals, have been invaluable.

COVID-19 Has Been a Test for Providers, but More so, Auto Insurers

The COVID-19 crisis has been a test for many industries, not least the auto insurance industry, and for us as restorative health professionals whose services are delivered to injured and ill individuals in both home and clinical environments. On April 28, our President, James Campbell, wrote to you and Ms. Elliott, in which he constructively alerted you to some unintended consequences of **Reg. 119/20**. One of those consequences was insurers' overly restrictive- and in our view, opportunistic- interpretations of the emergency measures that led to denials of legitimate virtual services for needy, at-risk patients. He brought our unfavorable experiences, and indeed the experiences of our peers, to your attention in his letter.

Since James's letter, FSRA has issued its Unfair and Deceptive Practices bulletin encouraging insurers to accommodate well-supported requests for virtual services. We are grateful for FSRA's actions because they are having their intended effects in a number of cases, making it possible to move forward with needed care for patients. However, judging by the sudden increase in the number of demands for lengthy and unnecessary proof-of-service declarations from claimants (i.e. those same patients), and us as providers, it has become apparent to us that FSRA's intervention is being viewed by some insurers as unnecessary meddling in their claims adjudication territory.

We have never been suspected of questionable claiming practices, and our FSCO/FSRA provider audits have always resulted in favorable reviews; yet the way claimant letters are being worded, one is given the impression that the claimant's health provider (us) is suspected of having performed a fraudulent act. Payment of invoices for prior-approved services actually performed

is being withheld pending the submission of those declarations, when a simple phone call to the claimant by the insurer would accomplish the same fraud avoidance purpose.

Insurers' resistance to virtual services, when the method of proposing and claiming for them had been created by them years ago-but not disclosed to claimants or health providers until well over a month into the emergency measures-is still problematic. Then there is the outright hostility to the FSRA bulletin noted above. Both demonstrate to us the urgent need to put the reform agenda back on track.

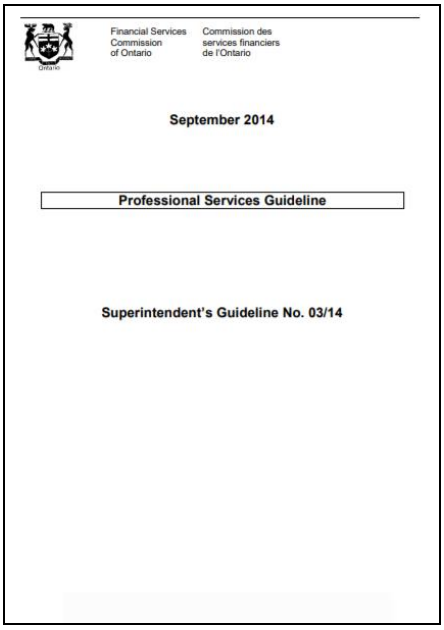
Our Past Contributions

Wanting to contribute to the reform dialogue when we believe we can make well-informed commentary, we sent Mr. Fedeli and Mr. Downey what could be termed a reform roadmap letter in February 2019. This past January, we also offered to participate on the FSRA **Technical Advisory Committee** by making the required letter submission. Both letters are appended to this letter.

Although we were heartened to hear Mr. Fedeli announce in April last year that the catastrophic injury lifetime maximum of was being restored to its original $2 million level, we are mystified why no further details have been released. This is one aspect of beneficial reform that requires action, and another argument for why the reform agenda needs to be resurrected.

There is one other area of glaring industry neglect that has been crying out for attention under the reform agenda, which is the fee schedule to which we are subject as providers of services under the SABS. Below, I have provided you with images of (1) the cover page of the FSCO/FSRA document and (2) the fee table.

Cover Page of the Professional Services Guideline



Financial Services Commission of Ontario | Commission des services financiers de l'Ontario

September 2014

Professional Services Guideline

Superintendent's Guideline No. 03/14

Fee Table Contained in the Guideline Document

APPENDIX – REVISED RATES AND FEES

Health Care Profession or Provider	Maximum Hourly Rate *except catastrophic impairments*	Maximum Hourly Rate *catastrophic impairments**
Chiropractors	$112.81	$135.36
Massage Therapists	$58.19	$89.07
Occupational Therapists	$99.75	$119.92
Physiotherapists	$99.75	$119.92
Podiatrists	$99.75	$119.92
Psychologists and Psychological Associates	$149.61	$179.29
Speech Language Pathologists	$112.22	$134.17
Registered Nurses, Registered Practical Nurses and Nurse Practitioners	$91.43	$109.24
Kinesiologists	$58.19	$89.07
Unregulated Providers		
Case Managers	$58.19	$89.07
Family Counsellors	$58.19	$89.07
Psychometrists	$58.19	$89.07
Rehabilitation Counsellors	$58.19	$89.07
Vocational Counsellors	$58.19	$89.07

*This rate applies to all services rendered on or after September 6, 2014 to an insured person whose impairment is determined to be a catastrophic impairment as defined in the SABS whether such services are rendered before or after such determination is made.

Form	Maximum Payable for Completion of Form
Disability Certificate (OCF-3)	$200.00
Treatment and Assessment Plan (OCF–18)	$200.00
Automobile Insurance Standard Invoice (OCF-21)	$0.00

While we have a role to play in stabilizing the financial health of the insurance industry, since injury benefits account for more than 50% of all auto insurance claim costs, is a fee freeze that extends almost six years really the way to do it? Our mission in our professional lives is to make people better, not to indirectly fund insurer bottom lines.

The fee schedule is obviously out of step with prevailing "open market" fees for the same professions, making it difficult to compete with government-funded agencies such as hospitals, whose compensation levels generally increase with the CPI, for needed staff. The list of providers is also outdated. Social Workers, for example, so many of which provide services to injured persons, are regulated professionals, yet do not appear on the list; this despite the FSCO bulletin of April 2018 that acknowledges they are regulated professionals. Similarly, Registered Psychotherapists are regulated health professionals who provide countless sessional therapies to injured persons, but they are not on the list either.

How are Psychotherapists and Social Workers, who provide treatment services to injured insureds paid you might ask? The answer is that they have to negotiate their fee case-by-case, leading to a wide variation in fees actually paid. This in turn raises questions of claimant equity, since the payments are being made from claimant funds administered by the insurers. At this stage, a simple reform would be to set any fair rate for these professionals as an alternative to the

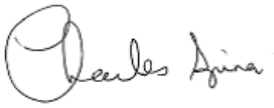
needlessly complex, inefficient process that is occurring now. Sounds simple, but evidently, unless it is done as part of the larger reform agenda, insurers will continue to inefficiently process these claims and the inequity is guaranteed to continue.

In conclusion, the need for reforms has been made all the more obvious by recent events and adjudication behaviours. Our MVA/AB client base numbers well over 1,000. We therefore have uncommon perspective on emerging patterns, which we have witnessed firsthand through our more than 80 regulated professionals throughout Ontario. We have never experienced the types of hostility toward claimants that we are witnessing now, and it gives us cause for great concern for the integrity of the entire Accident Benefits regime.

Either of us is available at any time to elaborate or discuss any of this letter's contents.

Sincerely,

Greg More, CPA, CA
Vice President Finance and Operations



Charles Spina, MBA
Vice President, Case Support Services