Ontario Chiropractic Association

November 29, 2024

Mr. Glen Padassery,
Executive Vice President, Policy and Auto/Insurance Products
Financial Services Regulatory Authority of Ontario (FSRA)
25 Sheppard Avenue West, Suite 100
Toronto (Ontario) M2N 6S6

Dear Mr. Padassery,

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Re: FSRA Auto Insurance Review Consultation (ID: 2024-011)

On behalf of the Ontario Chiropractic Association (OCA), I want to thank you for the opportunity to respond to the Financial Services Regulatory Authority of Ontario (FSRA) Reform Review Consultations on the Statutory Accident Benefits Schedule (SABS) Guidelines, the Health Service Provider Framework and the Health Claims for Auto Insurance (HCAI) system. We welcome FSRA's efforts to create a modernized and sustainable auto insurance system for Ontarians injured in auto accidents.

The OCA represents and advocates for more than 3800 chiropractors across Ontario. As musculoskeletal (MSK) experts, chiropractors assess, diagnose, and care for Ontarians injured in motor vehicle accidents with manual therapy, therapeutic exercises, patient education, and nutritional counseling. As highly trained and regulated community-based health care professionals, chiropractors work collaboratively with medical and other health care professionals in many programs and settings across the province.

The OCA was pleased to see the Ontario Government respond to our long-standing calls to modernize the province's auto insurance system in the spring budget. Building on the advance feedback OCA provided to FSRA on the three auto reform reviews in September 2024, we have specific feedback in response to the consultations on the 1) Professional Services Guideline (PSG) and the Minor Injury Guideline (MIG); 2) the Health Services Provider (HSP) framework (licensing), and 3) the HCAI system.

I. STATUTORY ACCIDENT BENEFIT SCHEDULE (SABS) GUIDELINES REVIEW

1.1 PROFESSIONAL SERVICES GUIDELINE (PSG)

Comments and Recommendations

The OCA supports and commends FSRA's stated guiding principle of reviewing the PSG to maintain care that consumers receive while also ensuring that regulated health service providers (HSPs) are appropriately compensated. Since 2014, neither the PSG (or the MIG) have been reviewed, amended, or increased. As a result, Chiropractors, working in the auto insurance system to provide care for patients injured in motor vehicle accidents are in their 10th year without a fee increase. During this same period, the cost of operating a business has increased significantly, making it difficult for chiropractors as small business owners to continue providing these services. It is challenging for chiropractors to meet inflationary pressures, which can impact the ability of chiropractic clinics to retain their staff.

Consequently, we recommend indexing (Option A) with the following caveats and recommendations:

i. **Existing base rates for chiropractors and all regulated HSPs on the PSG should be negotiated in good faith with each regulated health professional Association**, which is ideally positioned to provide input on their respective profession's market conditions, cost structure and salary trends.

ii. **Once existing base rates for chiropractors and all regulated HSPs on the PSG have been negotiated with each regulated health professional Association, a retroactive top up using the Consumer Price Index (CPI) should be applied to July 01, 2025** (and may need to be applied retroactively if FSRA changes occur after this date). A staggered approach should not be considered.

iii. **Implementing a comprehensive rate increase will reduce the administrative burden and complexity associated with multiple, incremental adjustments over several years.** It will also provide clarity and stability for regulated HSPs and insurers, helping them plan and adapt more effectively.

iv. **Going forward, indexation of these rates should be provided on an annual basis in continued collaboration with professional Associations**. If the PSG is not updated to reflect the costs of delivering care, the auto insurance system will continue to experience a loss of qualified and experienced regulated health professionals to other sectors. A lack of timely access to medical/rehabilitation care for patients in the auto insurance system will also increase pressures on Ontario's public health and social care systems, and result in decreased claimant satisfaction.

v. **To ensure timely communication regarding changes to the PSG, FSRA should work with professional associations and maintain its usual communication channels** (e.g., email bulletins, newsletters, and official websites).

vi. **To maintain a robust and sustainable auto insurance system FSRA should undertake a review of the three medical/rehabilitation benefit limits under the SABS** (i.e., the Minor Injury Cap, and the non-Catastrophic and Catastrophic Limits). As these limits have remained unchanged since 2014, in today's dollars, Ontarians have substantially less coverage than they had a decade ago to fund necessary care to restore their functioning to pre-accident levels.

vii. The word "maximum" should be removed from the description of hourly rates for both catastrophic and non-catastrophic impairments, as the PSG does not preclude insurers from paying rates above the maximum set on the PSG.

PSG Consultation Questions

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

The OCA recommends that existing base hourly rates for regulated HSPs on the PSG be negotiated in good faith between FSRA and each professional Association representing the regulated HSPs listed on the PSG. Professional associations are in the best position to evaluate and discuss rates on behalf of their members that are reasonable, fair, and well-premised for the Ontario market. Thereafter, indexation of these rates should be provided on an annual basis, based on the Consumer Price Index.

We believe that regulated HSPs working in the automobile insurance sector should be paid fairly for the critical and high-quality rehabilitation services they provide by the Statutory Accident Benefits Schedule (SABS). The PSG has not been reviewed, amended, or increased since 2014. As a result, current PSG rates no longer reflect reasonable and customary market rates for the services provided by regulated HSPs in this sector.

Increasingly, chiropractors and other regulated HSPs are choosing to leave the automobile sector due to low hourly rates paid under the PSG. Further, regulated HSPs who provide case management services to persons with catastrophic impairments report that it is becoming increasingly difficult for claimants to access qualified practitioners in their community who can provide the necessary rehabilitation services, particularly for psychological services/mental health care and, increasingly, occupational therapy. Our members working as sole practitioners and clinics operating in this accident benefits sector are either substantially decreasing the percentage of motor accident benefits cases that they accept or are actively pursuing to surrender their FSRA license altogether.

If the PSG continues in its current form and is not revised in a fair and timely fashion, OCA expects the following will continue:

- Loss of qualified chiropractors and other regulated HSPs to other sectors
- Pressure on the public health and social care system arising from lack of/timely access to necessary rehabilitative treatment providers with resulting poor recovery outcomes
- Increasingly limited access to chiropractors and other regulated HSPs in rural, underserved, and vulnerable populations
- Continued disputes at the License Appeals Tribunal (LAT) regarding fees for professions not listed on the PSG

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

The OCA does not support this option.

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

Since the PSG has not been updated since 2014, bi-laterally negotiated changes in each profession's base rates should be implemented fully and should be applied retroactively to July 1, 2025, as soon as possible. A staggered approach should not be considered.

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

The OCA recommends that fees for form completion be reviewed biennially.

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

The OCA does not support option C.

6) Are there other considerations related to rates/fees that should be considered for the PSG?

Regulated HSPs working in the accident benefits sector serve varying roles within their respective scopes of practice when providing services to claimants. For example, an occupational therapist may provide vocational counselling; occupational therapists, nurses, and physiotherapists often provide case management services as part of their role. As such, the PSG should clarify that services listed in the PSG and provided by a regulated HSP (regardless of whether the regulated HSP is listed on the PSG or not) are to be paid in accordance with a regulated HSP's professional designation and not by the services they provide. In doing so, the OCA submits that FSRA will substantially eliminate the possibility for dispute and prevent the need for adjudication on these issues at the LAT.

7) **Do you have any evidence that consumers are having difficulty obtaining the HSP care they need due to the existing PSG rates?**

A recent OCA survey of member chiropractors found that more than three-quarter of chiropractors working in the auto sector reported that their patients have difficulty obtaining care due to existing PSG rates.

8) **What are the key implementation considerations that must be taken into account for each option (i.e. timing, updates to billing systems, etc.)?**

See Section 1.1, Comments and Recommendations.

9) **How can FSRA help to ensure that any changes to the PSGs are communicated to HSPs, insurers, consumers and other stakeholders?**

See Section 1.1, Comments and Recommendations.

10) **Are there other considerations which have been missed that should be taken into account as part of the PSG review?**

Chiropractors and other regulated HSPs working in the accident benefits sector serve varying roles within their respective scopes of practice when providing services to claimants. As such, the PSG should clarify that services listed in the PSG and provided by a regulated HSP (regardless of whether the regulated HSP is listed on the PSG or not) are to be paid in accordance with a regulated HSP's professional designation and not by the services they provide. In doing so, the OCA submits that FSRA will substantially eliminate the possibility for dispute and prevent the need for adjudication on these issues at the LAT.

1.2 Minor Injury Guideline (MIG) and Minor Injury Cap (MIC)

Comments and Recommendations

OCA supports the original goals of the MIG as set out in 2010. A simplified administrative regime, with pre-approved funds and block fees for a set of health services for consumers whose injuries are predominantly minor, speeds access to rehabilitation and healthcare resource utilization and creates certainty around cost/payment for regulated HSPs and insurers. However, since 2014, neither the Minor Injury Guideline (MIG) nor the Minor Injury Cap (MIC) have been reviewed or updated. As a result, in today's dollars, Ontarians have less coverage than they had a decade ago -- and healthcare businesses in this sector (often small- to medium-sized clinics) are also finding it hard to meet the increased costs.

In accessing the funds under the Minor Injury Cap, overly burdensome and nonessential approval processes (for care that exceeds $2,200.00), coupled with insurer denials and partial approvals, create barriers to care for motor vehicle accident claimants with minor injuries, and generate backlogs at the LAT.

Since the inception of block funding originally designed in 2010, Chiropractors and other regulated HSPs identify that the same number of sessions typically occur in each block, despite reimbursement decreasing across blocks 1 to 3.[1] Providers who extensively use the guidelines should review this and consider whether there is sufficient flexibility in how funds are spent within the 12-week timeframe

Consequently, we recommend indexing the MIG (Option A) with the following caveats and recommendations:

i. **A simplified process for accessing the remainder of the minor injury cap ($1300) should be established to ensure a timely continuum of care and reduce disputes.**
ii. **The MIG should be indexed with an annual cost of living adjustment and a one-time top-up for 2025.**
iii. **Block funding under the MIG should be revised in consultation with regulated HSPs who extensively use the MIG to ensure adequate flexibility in the 12-week timeframe to support patient needs and health outcomes.**
iv. **To ensure timely communication regarding changes to the MIG, FSRA should work with professional associations and maintain its usual communication channels** (e.g., email bulletins, newsletters, and official websites).

[1] The current MIG block fees funding formula is as follows: Initial Fee: $215; Block 1-$775.00; Block 2-$500.00; Block 3-$225; Supplementary Fees: $400; Discharge OCF-24-$ 85.

MIG Consultation Questions

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

The OCA strongly recommends that SABS benefits should be annually indexed to This annual indexing is required at all benefit levels. This annual indexing is required at all benefit levels.

At the same time, all three benefit levels, the Minor Injury Cap, non-catastrophic and Catastrophic limits, under the SABS have not changed since 2014. As a result, in today's dollars, Ontarians have less coverage than they had a decade ago - and healthcare businesses in this sector (often small- to medium-sized clinics) are finding it hard to meet increased costs.

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

A retroactive cost-of-living increase using the CPI should be applied all at once.

3) Is the existing block fee structure/amounts for pre-approved MIG treatment appropriate? Why or why not?

Block Fee Structure:

Since the inception of block funding, originally designed in 2010, chiropractors have identified that the same number of sessions typically occur in each block, even though provider reimbursement decreases across blocks 1 to 3.

In a recent OCA , two-thirds of our member reported that Ontario's Minor Injury Cap is insufficient to meet the health care needs of claimants with minor physical injuries. This leaves many without needed care or facing delays in care to access further benefits beyond the Minor Injury Cap.

Many chiropractors identify the same number of sessions may occur in each block and yet the amount of reimbursement is different. This should be reviewed by providers who extensively use the guidelines. Flexibility of how funds are spent in the 12-week timeframe needs to be reviewed.

Pre-Approved MIG Treatment:

The MIG for simple soft tissue injuries allows the consumer immediate access to treatment funding without insurer interference. Presently, this occurs for the MIG ($2200). As indicated in Section1.3 Comments and Recommendations, the Coalition recommends that for the remainder of the minor injury cap ($1300), a simplified process to access these funds should occur to ensure a timely continuum of care and minimize debates.

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

FSRA should review MIG rates every 2-3 years

5) Are there other options/considerations related to rates/fees that should be considered for the MIG?

When multiple injuries occur, there are no mechanisms to provide additional care except for supplementary goods. This has been reported to be insufficient funding for an injured claimant that has suffered multiple soft tissue injuries.

6) Do you have any evidence that consumers are having difficulty obtaining the HSP care they need due to the existing MIG rates?

A recent OCA survey of member chiropractors found that more than two-thirds of chiropractors working in the auto insurance sector reported that Ontario's Minor Injury Cap (MIC) is insufficient to meet the health care needs of claimants with minor physical injuries. This leaves many without needed care or facing delays in care to access further benefits beyond the MIC.

7) What are the key implementation considerations that must be taken into account for each option (i.e. timing, updates to billing systems, etc.)?

The one administrative issue is the use of employer based extended health care for minor injuries. The OCA expects this will be addressed based on the government's commitment to make Auto Insurance a first payor.

8) How can FSRA help to ensure that any changes to the PSGs are communicated to HSPs, insurers, consumers and other stakeholders?

Communicate directly with all Licensed regulated HSPs and work closely with professional Associations to share information with their members.

9) Are there other considerations which have been missed that should be taken into account as part of the MIG review?

Programs of Care:

OCA, as a member of the Coalition of Health Professions in Auto Insurance (the "Coalition") has been participating in development and review of Programs of Care in auto insurance since the introduction of the Whiplash and Associated Disorder (WAD) protocols in 2003. These include the Pre-approved Framework (PAF), and the Minor Injury Guideline (MIG).

In addition, the OCA supports the following principles regarding the development and use of Programs of Care, which we believe should guide the exploration and implementation of any changes to the MIG:

- Best practice as well as current scientific evidence
- Providing a guideline rather than being prescriptive in treatment protocols to allow for health care provider expertise and patient choice, respecting all three components of evidence-based care
- Requiring ongoing re-evaluation based on new and emerging evidence-based practice
- Collaborative development with the healthcare Professional Associations representing the regulated HSPs who will implement them
- The patient population it serves regarding type, severity, and concurrence of injuries and pre-existing conditions
- Timely access to treatment while removing barriers to timely care
- Reducing administrative burden
- Decreasing the adversarial nature of adjudication experienced within the insurance context
- The present experience with MIG has led to many disputes and misunderstanding of the definition.

II. HEALTH SERVICE PROVIDER (HSP) FRAMEWORK (LICENSING) REVIEW

Comments and Recommendations

Chiropractors, like other regulated HSPs in Ontario, have Colleges that regulate their professional practice, including standards related to billing practices. As a result, FSRA licensing is a duplication leading to confusion and transparency issues regarding accountability. Further, many Chiropractors and other regulated HSPs have only a small part of their practice focused on auto claims. FSRA's licensing process continues to add unnecessary time and financial burdens for regulated HSPs.

OCA recommends that full licensing processes remain in place for businesses owned by non-regulated HSPs, who are often unaware or do not understand the professional standards and requirements to which chiropractors and all regulated HSPs in Ontario must adhere.

i. To reduce red tape, risks, and costs for patients in the system without sacrificing public protection, we recommend that:

ii. FSRA licensing, including registration processes, should be streamlined with costs lowered for regulated HSPs to recognize existing regulatory oversight.

iii. FSRA retain full licensing processes and costs only for the businesses owned by non-regulated HSPs.

Health Service Provider (HSP) Framework Consultation Questions

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

As we have stated above, the regulated HSP licensing system should be streamlined in recognition of existing regulatory oversight. To avoid duplication, a modernized licensing system should rely on existing, publicly available Regulatory Health College (RHC) registry data on the Health Service Providers (HSP), such as the following: name, practice locations and business name(s), business contact information, and license standing and restrictions, where applicable. HSP license numbers are often partially redacted, so collecting this information will require consent.

Although some of this information is publicly accessible, a data sharing agreement between the RHC and FSRA with member consent in the licensing process is highly

recommended for transparency between FSRA and its members. The data collected by the licensing system should interconnect with the HCAI system to a) reduce redundancy in reporting by regulated HSPs, and b) reduce administrative errors in reporting, resulting in improved efficiency and functionality.

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

Yes. As regulated HSPs, we fully support a transparent and accessible database and analytics strategy to oversee the auto insurance industry. To that end, OCA would like to be involved in designing and implementing (both new and existing) data collection, data analysis and data reporting processes that underpin any HSP Supervisory Tool. Additionally, regulated HSPs should have access to both data reports and databases to conduct analyses to inform practice management and care. Ontarians should also have access to data on claims handling practices to support informed decision-making when purchasing accident benefits.

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

Regulated HSPs have a statutory mandate to register and regulate HSPs in Ontario. With this mandate, there is a responsibility to limit licensure, impose terms and conditions or further disciplinary action, when in the public interest. From an administrative justice and fairness perspective, regulated HSPs are exposed to restrictive, redundant reporting and regulation processes between their Colleges and FSRA. Outcomes for College Reports and investigations related to auto insurance fraud should inform FSRA's licensing and supervision processes, and the RHCs should be consulted on advancing this model.

4) **What are the key implementation considerations that must be taken into account for each initiative (i.e., timing, communication, education, etc.)?**

As stated in our response to Question 2, the OCA supports a transparent and accessible database and analytics strategy for oversight of the auto insurance industry. To that end, the OCA would like to be involved in designing and implementing (both new and existing) data collection, data analysis and data reporting processes that underpin any HSP Supervisory Tool. Further, to increase efficiency in data sharing and licensing, FSRA should collaborate with RHCs and professional Associations.

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

The OCA can partner with FSRA in communicating upcoming changes and be trusted sources of education and dissemination for ongoing education. Public-facing education is

also a very important consideration and is a core role for FSRA in conjunction with RHCs and professional Associations.

6) **Are there any considerations which have been missed that should be considered as part of the HSP review and/or the proposed initiatives?**

We believe that the HSP Framework and HCAI reviews should be viewed from a holistic perspective. For example, regulated HSPs (and motor vehicle accident claimants) should be permitted real time access to services provided (or received) as a way to reduce the risk of abuse in the system. Further, we recommend the use of the Credential Tracker be resumed. This tool permits regulated HSPs to see which healthcare facilities have registered their credentials to bill insurers in the HCAI system. The regulated HSP then reports any concerning activity to HCAI. This process should be further developed to allow regulated HSPs and patients to check all applications and invoicing in their name in real time.

III. HCAI Review

Comments and Recommendations

The OCA supports FSRA's efforts to modernize the Health Claims for Auto Insurance (HCAI) system to create a more streamlined and efficient process for managing health claims. Guided by the principles of standardization, fitness-for-purpose and responsiveness, a modernized HCAI system can reduce red tape and administrative burdens on HCAI end-users, improve communication among insurers and regulated HSPs, and ensure cost-efficient and effective delivery of health care benefits to Ontarians injured in motor vehicle accidents.

To create a modern, efficient, and effective HCAI system, we recommend that FSRA:

i. Establish a mechanism or Working Group for stakeholders to improve the operational effectiveness of HCAI.

ii. Conduct a comprehensive review of the current HCAI system with a view to confirmation of the Health Intervention Codes which are considered reasonable/necessary.

HCAI Consultation Questions

1) **Which initiative(s) should be prioritized? Why?**

FSRA should establish a mechanism or Working Group for stakeholders to support and enhance modernization efforts. We recommend that FSRA's first priority be establishing a

mechanism or forum for stakeholders to improve the operational effectiveness of HCAI. The Forum should include HCAI end-users along with insurance adjusters. The Forum's terms of reference should include advising FSRA on key outcome data/improvements to existing HCAI forms.

As all three FSRA Reform Review initiatives are related, an established group could efficiently provide integrated recommendations. This approach would support the ultimate goal of modernization by creating a system with a simpler process to manage health claims and provide regular data to ensure decisions on future products are based on proper data analysis.

2) **Are there any significant benefits/drawbacks, including potential stakeholder impacts, missing from the analysis set out above that should be included?**

We believe the HCAI Reform Review consultation should adopt a holistic view of HCAI as an integral component of a revised regulated HSP Licensing system. For example, when a common registration occurs, HCAI should facilitate a seamless and simpler experience with data sharing to fill all subsequent fields and forms. The system should also permit regulated HSPs (and motor vehicle accident claimants) to track in real time healthcare services provided (or received), thereby reducing the risk of abuse in the system.

3) **Are there any considerations which have been missed as part of the analysis set out above that should be included?**

As part of efforts to modernize and improve the operational effectiveness of the HCAI system, we recommend a comprehensive review of the coding system (including Health Intervention Codes) to determine which codes are reasonable/necessary and whether additional educational resources might be required to ensure codes are being understood and used correctly. This work can be undertaken as part of the HCAI form review.

To improve service to Ontarians, claims adjudication and remove unnecessary administrative burdens and red tape, we recommend that the HCAI tool enable more effective communication between insurers and regulated HSPs/patients. Better use of existing comment fields for interactive dialogue and automated notifications would help reduce and resolve disputes more quickly (e.g., a notification to signal when a claim has been approved or whether an Independent Examination has altered a claims decision).

4) **What are the key implementation considerations that must be taken into account for each initiative (i.e., timing, communication, education, etc.)?**

As we have noted, there is a need for comprehensive, accessible shared data. We recommend further development of a more comprehensive, accessible database to give

the government and all stakeholders information regarding utilization, costs, and outcomes to evaluate how the system meets their priorities and concerns.

5) **How can FSRA help to ensure that prioritized initiatives / changes are communicated to HSPs, insurers, and other stakeholders?**

There are opportunities to directly communicate to HSPs through E-blast and through other initiatives undertaken in collaboration with professional associations and regulatory colleges, which are well-positioned to engage their members. It is also recommended that Q&A be used to engage with clarity.

6) **Are there any other opportunities for administrative and cost efficiencies that FSRA should consider to make the HCAI system more modern and efficient that are not included in the list of initiatives above?**

To support modernization goals, HCAI and the HSP Framework (Licensing) system should be reviewed holistically.

Thank you again for providing this opportunity for feedback. We look forward to collaborating with you to support implementing planned reforms to modernize auto insurance and enhance the provision of chiropractic care for motor vehicle accident patients across the province.

Regards,

Caroline Brereton, RN, MBA
Chief Executive Officer