Ontario Psychological Association

FSCO 2014 Draft Statement of Priorities

Review by the

Ontario Psychological Association

May 2014

ONTARIO PSYCHOLOGICAL ASSOCIATION

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Executive Summary

The Ontario Psychological Association's Auto Insurance Subcommittee is pleased to submit this review of the document, " *The FSCO 2014 Draft Statement of Priorities*". The 2014 Draft Statement of Priorities reflects the fact that Ontarians want reductions in auto insurance costs and premiums. The OPA is committed to working with FSCO and other stakeholders to achieve this goal. There are risks of further harm to accident victims with mental disorders and brain injuries if inappropriate cost control mechanisms are not employed. The OPA wishes to work with FSCO to mitigate those risks.

It has been well documented that Ontarians with mental disorders lack timely access to necessary mental health services.[1] The result is personal suffering and disability at the individual and family level and far-reaching costs for society and our provincial health care system. In the publicly funded health system, persistent regulatory and funding barriers interfere with patients' access to mental health services, including critically important and evidence-based services provided by psychologists.

In the auto insurance sector, barriers limit patient access to psychologists for assessment and treatment of mental disorders and brain injuries. These include legal requirements for physician certification of the existence of catastrophic impairment (for No-Fault insurance) and tort evidentiary rules that apply only under the *Insurance Act* and which mandate that only the evidence of a physician can be adduced to support a claim. Together, these restrictions act as barriers to access to treatment and impose additional costs on accident victims. These matters also fail to recognize the significant expertise and relative cost-effectiveness of psychologists in these matters. Indeed, in many circumstances, physicians turn to psychologists due to the quality of our assessments, diagnosis and care planning capabilities, and ability to triage to the right provider in the right payment scheme.

Background

No-Fault accident benefits were introduced to provide timely access to treatment and rehabilitation for those injured in auto accidents. In addition, No-Fault benefits can help to avoid the shifting of costs and demand to the already under-resourced public health care system.

In recent years, however, efforts to reduce insurance premiums have created significant barriers to access No-Fault benefits for Ontarians whose injuries take the form of mental disorders. While mental disorders create significant disability, they are often "invisible". All too frequently, their victims experience discrimination and denial of their claims. Where claims are accepted, mental disorders are usually quickly dismissed as being "minor injuries" simply because the seriousness of the injury is not always visible. This is even more problematic due to the documented inadequacy of publicly-funded services.

Accident victims with mental disorders resulting in catastrophic impairments face even greater challenges. Since 2003, injured Ontarians have been required to adduce physician evidence in addition to any evidence provided by their own psychologist in tort proceedings, which acts as a major barrier for justice for those with mental disorders in tort proceedings. In 2010, a regulation change stated that only physicians (with the exception of allowing neuropsychologists

[1] Included by the Ontario Legislative Assembly's Select Committee on Mental Health and Addictions in its (2010) Report.

when the impairment is only a brain impairment) would be permitted to certify the existence of a "catastrophic impairment" for the purposes of the *Insurance Act*, even though psychologists are often better placed and have the expertise to carry out this assessment and certification. Prior to 2010, psychologists were able to certify catastrophic impairment; the reasons for this regulatory change remain unclear. While the OPA agrees with taking action to reduce auto insurance fraud, it cannot support changes that have the result of unfairly limiting access for accident victims to insurance claim reimbursement for mental disorders.

Options to Reduce Costs and Minimize Risk of Further Harm

We support initiatives to find other areas of cost savings, such as in the towing and storage industry. While there have been significant reductions in funds available for treatment and rehabilitation services for injured Ontarians, there has been a lack of discussion of other options. The following are other areas that should be considered:

Public Auto Insurance Vs. Private Auto Insurance: The current **private** auto insurance system compared to other **public** systems creates less of an incentive to invest in accident prevention remedies since the costs are not integrated. To provide an example, in British Columbia, if an intersection has a disproportionate number of accidents, the cause is addressed and the number of accidents and claims costs are reduced.

Non-Accident Benefit Cost Drivers: We have reviewed the cost data available. The pattern we see over time is a reduced percentage of total funds being paid to accident victims through Accident Benefits and Tort. At the same time, there is an increased proportion of premium dollars being paid for commissions, general expenses, profits and taxes. These should be addressed as they account for approximately one third of the costs in the system and offer opportunity for significant savings. Significant variability in these areas across insurance companies suggests that some have found opportunities for cost savings.

Internal Claims Adjudication Practices of Insurance Companies: These vary greatly across companies even though they are operating within the same regulations. While some companies have relatively fair and efficient processes, others are highly inefficient and generate needless delays and costs. Still others disregard evidence-based treatment guidelines and take an overtly adversarial position with any claimant whose injuries are less visible, such as those with mental disorders. These practices contribute to higher levels of distress in already compromised clients. Additional distress combined with delays in provision of care leads to increased disability and treatment costs and subsequent higher levels of dispute and Tort costs.

There are a number of options to improve access to services under No-Fault benefits for accident victims with mental disorders. Some options include:

- Improve education regarding the nature of mental disorders, with the aim of reducing discrimination and overcoming the continued narrow focus on severity of physical injury as a proxy for mental injury;
- Create and enforce standards for proper adjudication, including consideration of the relevant evidence-based guidelines regarding assessment and treatment of mental disorders when making decisions;

- Require insurer examiners to have appropriate training and expertise, utilize a professional peer reviewer whenever appropriate, rely upon psychologists to diagnose mental disorders, comment on reasonable and necessary treatment, and resultant disability; and,
- Restore the appropriate role of psychologists to certify applications for catastrophic impairment determination and to be relied upon as the sole expert to adduce evidence regarding mental disorders in tort-based legal actions under the Insurance Act.

Key Recommendations

The OPA fully supports the need to address auto insurance cost pressures. Our members' main concern remains the need to implement processes that do not have the unintended consequence of furthering systemic discrimination against clients with mental disorders. While each section of this paper provides specific recommendations to a FSCO priority, the following are our key recommendations:

- Protect access to necessary psychological services for accident victims with mental disorders;
- Continue to acknowledge that mental disorders are not "minor injuries";
- Do not make changes to the catastrophic impairment criteria that require an even higher level of impairment for those with mental and behavioral disorders than for those with physical disorders;
- Re-instate provisions to reflect expertise and competence of psychologists by allowing them to certify catastrophic impairment applications due to mental disorders;
- Do not reduce the supply of psychological treatment providers by imposing disproportionate licensing fees on psychologists who only treat a few patients under auto insurance. Provide a limited exemption from licensing fees for these regulated health professionals; and,
- Re-instate reliance on a psychologist, with appropriate expertise, to be the sole expert to adduce evidence about impairments due to mental disorders in the Insurance Act tort threshold.

About the Ontario Psychological Association (OPA)

Founded in 1947, the Ontario Psychological Association (OPA) is a voluntary professional association that promotes the mental health and well-being of Ontarians by advancing the profession of psychology through research, education, clinical excellence, leadership and advocacy. The OPA is proud of the sound and reasoned work of the Auto Insurance Subcommittee in undertaking this review of the FSCO 2014 Draft Statement of Priorities. The members of the OPA Auto Insurance Subcommittee would welcome the opportunity to meet with you to discuss options to further reduce costs without causing further harm to vulnerable accident victims with mental disorders.

1.0 Licensing Business Systems and Business Practices of Service Providers

1.1 The Key Statement

"In the 2013 Ontario budget, the government committed to take further action to tackle fraud in the auto insurance sector. Among other measures, the government expanded FSCO's mandate to include the licensing and regulation of the business systems and business practices of healthcare service providers that directly invoice auto insurers for statutory accident benefits. In 2014, FSCO plans to launch a licensing regime to reduce fraudulent billing practices in the sector".

1.2 Psychologists are Regulated Healthcare Professionals

It is important to remember that psychologists are regulated healthcare professionals. Doctorate-level psychologists have 10 -12 years of education and supervision prior to licensure by our regulatory body, the College of Psychologists of Ontario (CPO). The College already regulates our billing and business practices and addresses all complaints raised by any party including those related to business practices. The OPA firmly believes that an additional licensing system with associated additional costs for regulated health professionals is not needed. The OPA does support, however, that there is a need for a mechanism to address business practices of facilities that are not owned or directed by regulated healthcare professionals.

These additional costs are being imposed on psychologists at the same time that there has not been any recent increase in the hourly fee schedule. The present fee schedule (PSG) remains lower than the accepted fee under auto insurance in 2001. As a result, some psychologists have reluctantly reduced the number of patients injured in a collision in their practices and others are no longer accepting referrals for these patients. The remaining psychologists have been coping with absorbing increased costs with reduced fees. The OPA understands that the government is determined to implement a licensing regime that includes all facilities billing insurers including those owned or directed by regulated health professionals. Given that regulated healthcare professionals are already governed by their own Colleges (including their business practices), the licensing processes should be streamlined and associated fees potentially lowered for facilities that are under their ownership or direction.

1.3 Patient Access Remains a Prime Concern

The fee license model must protect patients' ability to access appropriate treatment providers of their choice. The question of health professional providers who only treat a small number of accident victims within a general practice and/or in undersupplied rural areas, and/or for patients with specific needs was raised in various forums. Reassurance was provided that, "*there was no intention to discourage this model of practice*" or to cause further problems with access in underserviced rural areas and/or for patients with specific clinical, age-specific, cultural and/or language needs. In fact, it was stated that, "*it would be inappropriate to interfere with accident victim's ability to access these treatment providers*". It was indicated that it was toward this goal that the fees would be "**proportiona**l" to the relative burden of the costs. This principle of

proportionality is repeated in the Frequently Asked Questions that were posted along with the announcement of the fees and fee structure (see reference information).

1.4 A Shortage of Psychologists Equals Reduced Access to Expert Services

There are relatively few patients who receive psychological treatment; however, there are also very few psychologists who are available to provide treatment to patients with mental disorders resulting from auto accidents. There is a perception that there are more psychologists available in the province to provide care for patients. In actual fact, the number of available psychologists presently registered with HCAI is inflated since a significant proportion is involved in the provision of Insurer Examinations only. There is an outright shortage of psychologists generally and especially in rural areas, as well as to address specific clinical and age-specific, cultural and language needs. Care must be taken to ensure that the licensing proposal does not further reduce access to service for accident victims with mental disorders. Several of our members have reported that they provided treatment to a single patient (or a very limited number) under auto insurance in the past year. These psychologists reported that they agreed to see these patients and registered with HCAI because their specific expertise was required. In many instances, an alternative psychologist was not available. They indicate that they registered with HCAI because it was necessary to be able to bill the auto insurer directly. They are all too aware that most clients' limited financial situations would prohibit access to treatment if they had to pay for the services and then be reimbursed by their insurer. Any change to the system that promotes a US-style of upfront direct payments is an affront to the principles of equitable access to care.

Low volume and highly needed psychologists have pointed out that the cost to become licensed to be able to bill for one patient is $480.

> This total is $480.00 and includes:
> - A one-time license application fee of $337; and,
> - An annual regulatory fee of:
> - $15 multiplied (x) by the total number of unique statutory accident benefit claimants in the calendar year before the year in which the application is made; plus (+)
> - $128 multiplied (x) by the applicant's total number of business locations at the time the application is made.

The cost of $480 is not proportional to the costs of the treatment services provided to a single patient. These psychologists have indicated that it makes no business sense to continue to obtain the license necessary to continue to provide services billed to the auto insurer and that they will not be able to continue if the licensing fee is required, referring to the licensing program as the "straw that broke the camel's back". If even some of the limited pool of treating psychologists withdraw from the program due to disproportionate licensing fees, it will create an obstacle to access to necessary services for the patients with mental disorders. Simply stated: there must not be a disproportionate and excessive financial barrier to licensing for psychologists with very limited practices under auto insurance. They are an essential resource for access to treatment for those accident victims with mental disorders. This would be especially problematic for access to

services patients with mental disorders in underserviced rural areas as well as for those with specific clinical, cultural or language needs.

1.5 Recommendations

The OPA would welcome the opportunity for greater involvement in the development and implementation of the changes that will result in greater cost containment for auto insurance. To reduce the potential for unintended consequences, the OPA is recommending that FSCO:

- Create a very limited exemption from the license fee for clinicians who have received payment for only a few claimants in the previous calendar year (Given the relative rarity of this situation, this accommodation will not interfere with cost recovery within the overall licensing model);
- Develop due processes to be used for the protection against vexatious complaints and unreasonable removal of licensed status;
- Ensure direct and timely payments to all licensed health professionals by all insurers (This is doable since the program means that health professionals will be taking on an increased cost and administrative burden and insurers will have confidence in the business practices of those who are licensed); and,
- Fund relevant continuing education opportunities for all who are licensed (For example, an annual update regarding any changes in the SABS requirements relevant to health professionals).

2.0 Development of a Minor Injury Treatment Protocol

2.1 The Key Statement

"FSCO has contracted scientists and medical experts to develop an evidence-based protocol to treat auto accident claimants who sustain minor injuries.

The protocol will inform the Superintendent when developing a revised Minor Injury Guideline. The revised Minor Injury Guideline will be consistent with current and scientifically proven treatment for common injuries resulting from motor vehicle accidents. This will reduce disputes about benefits, and improve care provided to claimants".

As was stated in the OPA's submission for the Three Year Review, we continue to be fully supportive of evidence-based treatment. The OPA has published **evidenced-based guidelines** for assessment and treatment of psychological disorders resulting from auto accidents. Findings from relevant research should be incorporated into the Guideline for the treatment of minor injuries. Accident victims with mental disorders, however, must not be subject to further harm by misclassifying their disorders as ***minor injuries***.

2.2 Review of the Development of the Protocol

Members of the Committee had the opportunity to hear Dr. Cote's initial presentation on the status of his group's work. The group has reviewed a great deal of research. Unfortunately, in

spite of identifying a vast number of studies (120,864), very few (157) demonstrated the characteristics (methodological soundness) necessary to be included for further analysis. Of those retained, there are a few that show that "x" treatment is useful for "y" condition, according to the results of the particular study. As stated in the presentation session, there was little basis in the research cited to provide confidence in the replicability or generalizablity of any of the findings. Specific research was not presented regarding the applicability of these findings to those who experience auto collision injuries. It is important to note that there are challenges in attempting to transfer these research conclusions to the auto accident context. There are differences in the population and the mechanism and nature of the injury. Importantly, auto collisions often result in multiple injuries. Unfortunately, most of the studies focus on treatment of individuals with single injuries.

The OPA understands that Dr. Cote's research group will now be working on developing an "evidence-based Minor Injury Treatment Protocol for the management of individuals injured in traffic collisions". In the presentation materials, the terms *guideline* and *protocol* seem to be used interchangeably. In clinical practice there are large differences.

1. ***Protocols*** generally prescribe very specific interventions to very precisely defined populations with narrow and specific inclusion and exclusion criteria.

2. In contrast, ***Guidelines*** acknowledge that the treating health professional must select from a range of interventions according to the needs and responses of the individual patient.

If the protocol is intended to be applicable to large numbers of accident victims, we assume that the intention is to develop a more open and flexible *Guideline* to be modified by the health professional according to the variable needs of individual patients. Moreover, the OPA would like more information regarding the process proposed for the translation of the research evidence into the treatment Guideline.

The most commonly accepted definition of evidence-based practice is as follows:

"EBP is the integration of clinical expertise, patient values, and the best research evidence into the decision making process for patient care. Clinical expertise refers to the clinician's accumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal preferences and unique concerns, expectations, and values. The best research evidence is usually found in clinically relevant research that has been conducted using sound methodology". (Sackett D, 2002)

During the presentation (but not included in the notes subsequently made available) Dr. Cote indicated that the Guideline would be based on four factors:

- Effectiveness;
- Cost effectiveness;
- Patient's preferences;
- Ethics and social values; and,

- Feasibility within Ontario auto insurance system including both ethical aspects and political/ regulatory aspects.

The OPA understands that the research review may contribute to an understanding of the effectiveness of various treatments and some information regarding cost-effectiveness. While there may be some useful research showing what not to do, given the limitations of the studies, "absence of evidence" cannot be presumed to mean that there is documentation that a treatment is **not** effective.

In addition, the research presented (as well as our understanding of the study of preferences being conducted with a small selected group of insureds) does not replace the preferences of the individual patient receiving the treatment. Patient preference and decision-making (i.e. patient-centred care) is a key principle in all health care.

The OPA also noted that Dr. Cote did not include the following component of evidence-based practice identified in the definition above, "Clinical expertise refers to the clinician's accumulated experience, education and clinical skills**".** He may have presumed that the treating health professional always has the responsibility and authority to determine the treatment they provide to the individual patient. These components of the evidence-based guidelines needs to made explicit.

In addition, there were indications that the timeframe of the Guideline from the present model for early intervention (first 12 weeks) might be extended.

The OPA also noted in the presentation some suggestions of broadening of the minor injury definition. We note that in his materials and presentation, Dr. Cote has made reference to Mild Traumatic Brain Injury (Concussion) as an additional "minor injury" to be considered for inclusion in the "minor injury treatment protocol". To be clear, MTBI reflects a *brain injury*, and as such, it cannot be considered a minor injury. The complexity of these issues is reflected in the report by the Ontario Neurotrauma Foundation (ONF) which has recently involved a large multidisciplinary group to produce the second edition of evidence-based "Guidelines for Concussion/Mild Traumatic Brain Injury & Persistent Symptoms", (2013). These guidelines are highly credible and methodologically sound, reflecting the state of the art, best practices in relation to this patient population. It is not reasonable to address any brain injury in the context of the MIG**.** *Rather, brain injuries should be explicitly exempt from the MIG.*

In addition to Dr. Cote's work, there appears to be some other pressures to inappropriately include some mental (psychological) disorders within the Minor Injury definition, funding cap and Treatment Guideline. It is fundamentally wrong to confuse psychosocial issues which are addressed as a part of a minor injury with mental disorders. Inclusion of mental disorders in the minor injury definition is not only scientifically incorrect, it would cause further harm to the relatively small, but highly vulnerable group of accident victims with mental disorders.

Distinguishing psychosocial issues treated within the MIG from psychological disorders, which are not minor injuries, was addressed in detail in the OPA submission for the Three Year Review. ***Classifying mental disorders as "minor injuries" would cause further harm to this already vulnerable subset of accident victims***.

2.3 Psychosocial Issues are Appropriately Addressed Within the MIG

Some accident victims with minor physical injuries may also present with psychosocial issues (symptoms/complaints) which are appropriately considered within the Minor Injury (MI) cap and addressed within the Minor Injury Guideline (MIG). These issues and services are illustrated in the section on supplementary goods and services in the MIG, "*Supportive interventions such as advice/education to deal with accident-related psycho-social issues, such as but not limited to: distress; difficulties coping with the effects of his/her injury; driving problem/stress".* However, the inclusion of psychosocial issues must not be inappropriately expanded and forestall the appropriate identification and treatment of accident victims' mental and behavioural disorders. These disorders are not minor injuries. To the contrary, the literature is unequivocal that psychological disorders have greater adverse functional impact than do physical impairments. There is a risk of discriminating against those with less visible impairments due to mental and behavioural disorders. Patients with these disorders are subject to a high level of social stigma, their impairments tend to be minimized, and there is a disproportionate lack of services in our public health care system.

2.4 Mental and Behavioural Disorders are Not Minor Injuries

The following sections demonstrate that mental and behavioural disorders are not minor injuries and can be easily differentiated from minor physical ailments and the distress that may accompany them.

2.4.1 Onset and Prognosis

Psychosocial issues/symptoms/complaints such as upset and distress in most accident victims with minor musculoskeletal injuries are generally noted soon after the accident. In most individuals, good recovery may be observed within days and usually within the general 12-week time frame of the MIG. In contrast, impairments due to mental and behavioural conditions/disorders are more likely to have later onset (the exception being acute stress disorder, post- traumatic stress disorder, and specific phobias) and tend to be persistent. While there are effective treatments for these pervasive disorders, reduction of impairments and restoration of functioning often requires months to years. The longer recovery times are dependent upon complicating factors and individual response to treatment. Early access to psychological approaches are known to be effective in mitigating complicating factors and, since they are tailored to the individual patient's needs, individual responses tend to be positive.

Given the nature of client responses, the subset of accident victims with impairments due to mental and behavioural disorders cannot be considered to have predominantly Minor Injuries or limited to the Minor Injury Guideline, as their onset is often delayed and prognosis is one of a more prolonged recovery. ***As such, the Minor Injury definition and Minor Injury Guideline should explicitly state that mental and behavioural disorders, documented by an appropriate health professional, are excluded from the MI definition and exempt from the MIG treatment Guideline, even when accompanied by minor musculoskeletal injuries.***

2.4.2 Functional Limitations

In addition to their persistence beyond the early post-MVA period, accident victims with psychological impairments due to mental and behavioural disorders can be differentiated from those with psychosocial issues/symptoms/complaints by the resultant functional limitations.

While some accident victims with minor musculoskeletal injuries may have psychosocial issues/complaints, these would not be expected to limit their functioning in their personal, home, or work life. The distinction occurs where mental and behavior disorders have developed to the degree that they result in impairment and limitation in functioning.

The higher level of disability due to mental and behavioural disorders is documented in *"Disability and Treatment of Specific Mental and Physical Disorders, Ormel, Petukhova, Von Korff, and Kessler, Global Perspectives on Mental – Physical Comorbidity in the WHO World Mental Health Surveys, edited by Michael R. Von Korff, et. al., Cambridge University Press, 2009*".

The key message is that "*Disability ratings for mental disorders were generally higher than for physical disorders. Of the 100 possible pair-wise disorder-specific mental- physical comparisons (Table 18.4), mean ratings were higher for the mental disorder in 91 comparisons in developed and 91 in developing countries".*

Therefore, a key component of appropriate mental health expert diagnosis of a psychological disorder involves evaluation of the impact on functioning. The mental and behavioural disorders require treatment in their own right to reduce impairment, restore function and reduce the likelihood of the disorder becoming a life- alerting chronic condition.

2.5 Assessment by a Health Professional with Expertise in Diagnosis of Mental and Behavioural Disorders

It is generally assumed that the screening for psychosocial issues and the need for supportive interventions can be provided by the health professional providing the assessment and treatment of the minor musculoskeletal injuries. The assessment section of the MIG states, "*It is understood that the review and documentation of functional status and psycho-social risk factors is within the scope of practice of the health practitioner and does not involve a formal psychological assessment".* It should be noted that psychologists are not included in the list of practitioners who can complete the OCF-23, MIG treatment confirmation form (Chiropractor, Dentist, Nurse Practitioner, Occupational Therapist, Physician, Physiotherapist). This is consistent with the focus of the Minor Injury definition and Minor Injury Guideline on minor physical injuries. Psychologists do not perform the assessments and examinations required by the MIG provider, including conducting the physical examination and determining the physical diagnosis.

In contrast, the determination of impairments/disorders due to mental and behavioural disorders requires specialized expertise and authority to communicate the diagnosis (authority to perform this controlled act is limited to some members of the psychological and medical profession). Assessments of accident victims with mental and behavioural disorders should follow the processes outlined in the OPA Assessment and Treatment Guidelines. When appropriately conducted, the psychological diagnostic process can be compared to medical laboratory testing to guide treatment/rehabilitation. If the health professional providing the physical treatment for the minor musculoskeletal injury suspects a psychological impairment, the patient should be referred for screening and determination of the need for diagnostic assessment/treatment to a regulated health professional with expertise in diagnosis and treatment of mental and behavioural disorders.

2.6 Treatment by Health Professional with Expertise in Treatment of Mental and Behavioural Disorders

It is assumed that the physical treatment provider can provide the supportive interventions required by accident victims with minor musculoskeletal injuries. The discretionary interventions during treatment section of the MIG Guideline states, "*If the insured person is displaying signs of distress or difficulties coping with the effects of his/her injury, the health practitioner may introduce pain management and coping skills education (a standardized approach is recommended)".* In contrast, patients with mental and behavioural disorders present with a variety of highly specialized treatment and rehabilitation needs. Effective, efficient treatment/rehabilitation must incorporate both evidence-based guidelines, when appropriate, and individual factors. This requires health professionals with specialized expertise. Extensive specific education and training is required to provide the treatment/rehabilitation in a sound manner. In addition, it is essential to continuously evaluate and monitor the effect of treatment and modify as needed. Therefore only health professionals with this specialized expertise, such as psychologists, should provide treatment/rehabilitation of patients with impairments due to mental and behavioural disorders (in coordination with other treatment, if required, for the patient's physical disorders).

2.7 Mental and Behavioural Disorders are Not the "Clinically Associated Sequelae" of Minor Musculoskeletal Injuries

As discussed above, an accident victim with impairments due to a mental and behavioral disorder has a distinct disorder/condition, not a "clinically associated sequelae" of the minor musculoskeletal injury. The nature and severity of the mental and behavioural disorder is independent of the severity of the physical injury.

2.8 Predominance of Mental and Behavioural Disorders

In patients with minor musculoskeletal injuries as well as impairments due to mental and behavioral disorders, the mental and behavioral disorder usually comes to overshadow that of the physical injury and becomes the predominant cause of functional limitations in home, personal and work life and creates the greater health care needs. Therefore, in accident victims with psychological/mental and behavioural disorders, as well as minor musculoskeletal injuries, the psychological disorder is the *predominant* condition.

2.9 Reduction in Disputes

The OPA noted that section 1.2 in the Draft Statement of Priorities concludes with the statement that: "***This will reduce disputes about benefits, and improve care provided to claimants***".

We fully support efforts to reduce disputes. It is particularly difficult, however, for accident victims with mental disorders to endure disputes regarding their applications for services since they reinforce the stigma and dismissal of their needs as "real" and appropriately requiring treatment. In addition, while an insurer may obtain an Insurer Examination which may ultimately approve treatment, excessive insurer denials add needless costs to the system. In addition, this requires the accident victim, with a mental disorder, to undergo an Insurer Examination and expose the most personal aspects of their life and recount what may be a highly traumatic event

to a health professional who will not be their treatment provider. This process is often associated with significant further deterioration. We have observed too many patients with mental disorders harmed by baseless insurer denial of their applications for approval for funding of services. The denial and delay in access to services is particularly harmful given the lack of alternative services in the public health system as documented above.

Therefore, it is particularly concerning to see that almost all applications for clinical assessment and treatment of mental disorders are denied by the insurer when the insurer has classified physical injuries as falling within the minor injury definition. We note that this occurs even when the patient is referred by the family physician that has identified a mental disorder and/or when there has been a comprehensive screening conducted by a psychologist documenting indicators of a mental disorder and need for psychological services. When the insurer denial is followed by an insurer examination, we note that these applications are ultimately approved in a very high proportion of the cases. Therefore, this needless denial is not only a burden for the patient that often results in worsening of their condition as treatment is delayed; it also adds costs and disputes to the system.

2.10 Recommendations re: Development of the Minor Injury Treatment Protocol

- Clarify that mental disorders, documented by an appropriate health professional, (psychologists and physicians are the only regulated health professionals who are authorized to communicate a diagnosis of a mental disorder) are not within the minor injury definition. This would reduce harm to accident victims with mental disorders and costs associated by inappropriate denials while ensuring appropriate identification of individuals with these disorders;
- Improve education regarding the nature of mental disorders, with the aim of reducing discrimination and overcoming the continued narrow focus on severity of physical injury as a proxy for mental injury;
- Create and enforce standards for proper adjudication, including consideration of the relevant evidence-based guidelines when making decisions; and,
- Require insurer examiners to have appropriate education, training and experience. When obtaining insurer examinations, insurers should utilize health professional peers to comment on assessment and treatment. As one of two professions qualified to determine diagnosis of mental disorder, comment on reasonable and necessary treatment, comment on disability and catastrophic impairment due to these disorders; rely on psychologists to conduct these insurer examinations.

3.0 Support for Cost and Rate Reduction

3.1 The Key Statement

The OPA supports efforts to achieve cost and rate reductions for auto insurance.

3.2 Rate Determination

"FSCO will support the government's implementation of the auto insurance Cost and Rate Reduction Strategy, utilizing the powers provided to the Superintendent in existing legislation. We provide comment on some of the elements in the cost and rate reduction strategy. AND, Providing the Superintendent of Financial Services with authority to require insurers to re-file rates".

The OPA believes that greater transparency and input regarding rate determination would be helpful to ensure that rates are reasonable and do not present as disincentives to care provision.

3.3 Licensing Transition Strategy

"Establishing a transition strategy for the licensing of health service providers that bill auto insurers so that only licensed providers can get paid directly by insurers".

See our comments above regarding licensing.

3.4 Auto Insurance Fraud

"Continuing to crack down on fraud, including licensing health clinics that invoice auto insurance companies; and,
Exploring the establishment of a special investigation and prosecution unit on serious fraud, including auto insurance fraud".

The OPA fully supports targeted efforts to reduce fraud. As health professionals we are very aware of the risk of fraudulent use of a health professional's credentials. We participated in the pilot study of the professional identity tracker. Misuse of psychologists' credentials was identified for further investigation. Psychologists have also received inquiries from companies seeking verification of services and been able to confirm that they have not provided these services. However the professional identity tracker pilot was only a preliminary step. We recommend further development of tools that will allow the health professional to be aware of all billings for activities that are in their name in real time. Only with this information can the health professional be reassured that billings are for services actually delivered.

3.5 Towing Industry

"Exploring other cost reduction initiatives, including provincial oversight of the towing industry and addressing collision repair practices".
"Reducing the amount of time a vehicle can be stored, accruing charges, after an accident without notice to the driver from 60 days to a shorter timeframe".

The OPA strongly supports initiatives to regulate the towing, storage and repair industry. It does not make any sense to require licensing and control of billing practices of health professionals, who are already regulated, and not to have greater control of these costs to the consumer. This is reported to be an area fraught with abusive practices. In addition, it is reported that instances of fraud and kick-back schemes often involve the tow truck driver.

3.6 Other Cost Reduction Measures

"Other cost reduction measures recently introduced included: limiting incurred expenses to economic loss for attendant care; restriction election of type of benefit; and requirement that documentation of pre-existing injury be from medical record completed prior to the MVA".

The effects of these measures need to be evaluated and modification considered. Since psychologists do not provide MIG treatment and generally do not determine need or amount of attendant care, we do not have direct experience to comment on these issues. The OPA understands that these measures were brought in to address areas subjected to reported instances of excessive costs. We understand, however, from our health professional colleagues, that these measures cause harm to injured individuals with legitimate needs. Further consultation with the relevant health professions may identify approaches that are more finely tuned to deal with individual instances of excess without harming those with legitimate needs.

3.7 Dispute Resolution System

"Transforming the Dispute Resolution System to help injured Ontario drivers settle disputed claims faster. Moving administration of the system from the Financial Services Commission of Ontario (FSCO) to the Ministry of the Attorney General's Licence Appeal Tribunal would help cut down on consumer frustration as well as curb financial and administrative stress on the system, which can increase costs and cause rates to go up".

We strongly support the need for faster mechanisms to resolve disputes. However, care must be taken to ensure that changes do not unfairly disadvantage the insured person and limit their access to dispute resolution.

3.8 Reduced Rates for Safe Drivers

"Continuing to require insurers to offer discounts for consumers with safe driving records."

We strongly support measures that reward and reinforce safe driving.

3.9 Recommendations

- Provide greater transparency and input into the determination of premiums;
- Provide direct payments to licensed providers;
- Develop tools to provide professionals with the information they need to assist with the crackdown on fraud;
- Continue to address issues related to the towing industry;

- Seriously consider other cost reduction measures and use the savings to invest in access to care;
- Revise the Dispute Resolution System to provide faster mechanisms to resolve disputes; and,
- Provide reduced rates for safe drivers.

4.0 Enhance Auto insurance Information and Analysis

4.1 The Key Statement

"FSCO will enhance the use of automobile insurance data to simplify its regulatory process and collect data to forecast future trends, including: Examining factors contributing to cost changes in third-party liability bodily injury, and releasing a final report on the findings in 2014".

The OPA understands that "Pinnacle" (this may not be the correct name of the organization) will be conducting the study. We understand that the study will be based on cases from the 2005 accident year. We understand that, "*it was determined to use 2005 since it was reasonable to assume that most cases from that time would have been settled. The study is looking for patterns in Bodily Injury and Accident Benefit claims".*

We would appreciate more information regarding the terms of reference and the design of the study. We note that while it is likely that the 2005 claims will have matured, the study will provide limited data to reflect on the present systems as there has been massive changes brought in since that time.

4.2 KPMG Auto Insurance Transparency and Accountability Expert Report

"Reviewing actuarial data to gauge the effect of the automobile insurance reforms, and studying the effect of the reforms on automobile insurance rate levels".

The OPA has reviewed the KPMG Automobile Insurance Transparency and Accountability Expert Report, Interim Report, April 14, 2014. The report repeats the insurance industry's claims that the government needs to bring in further cost controls for them to be able to achieve the targeted 15% reduction in premiums.

Recommendations in 7.4 states, however;

"With the work that has been performed as part of the Interim Report, we feel it is still too early to provide recommendations for further action to reduce costs and rates as the survey conducted in preparation of the Interim Report focused exclusively on the views of P&C insures operating in Ontario. As part of the 2014 Annual Report, we will expand the survey to seek input from other stakeholders in the insurance system who may have a different perspective to share with the Government".

The OPA is not aware of which stakeholders KPMG will involve in the next stage of their review or the process to provide input. We also were disappointed that a detailed analysis of various cost drivers within each insurance company was not completed to identify areas in which the companies could achieve savings to allow premium reductions. We note there is variability across companies in adjusting practices and non-accident benefit costs such as commissions, general expenses, profits and taxes, providing opportunities for cost savings.

4.3 General Insurance Statistical Agency – 2013 Statistical Data

"Working with the General Insurance Statistical Agency to collect Ontario's 2013 auto insurance statistical data, and analyzing the data to monitor automobile insurance cost changes and to review the reasonableness of automobile insurance rates".

We support ongoing review of data to ensure that premiums are not resulting in excess profit or allowing inefficiency by some insurers.

4.4 Health Claims for Auto Insurance System Reports (HCAI)

"Reviewing the Health Claims for Auto Insurance system to determine reports necessary to provide additional information on statutory accident benefits treatment trends".

We continue to support and participate through the Coalition to work with HCAI for determination of reports to provide meaningful information about the costs of the accident benefit system.

4.5 Required Additional Information

The HCAI system provides significantly more complete and timely information than was previously available. More complete standard reports will provide all stakeholders with better information about the costs of the system. Several examples of where additional information would be helpful to all stakeholders include:

- Reports regarding how many treatment plans are submitted, how many are denied, of those treatment plans that are denied by the adjuster and referred for an IE, how many are subsequently approved;
- Reports regarding number of treatment plans denied on the basis of the application of the MIG and outcome of any IE;
- Reports regarding specified benefits would also be useful to understanding the costs of the system. This would be particularly helpful as it might be possible gain information about classification of injury, amounts spent on treatment, and amounts paid for income benefits; and,
- Reports regarding numbers of catastrophic impairment applications, insurer approvals or denials, Insurer Examinations regarding Catastrophic Impairment status, and outcome.

4.6 Review and Implement Requirements for Usage-Based Auto Insurance

"FSCO will continue to work with the auto insurance sector to ensure consumers are fairly treated as more companies implement voluntary usage-based auto insurance programs".

We support the development of voluntary usage-based insurance programs and the ongoing work to ensure consumers are treated fairly and privacy is protected. If the science is sufficiently developed to allow for accurate prediction of risk, this type of behavioural feedback/reward mechanism has great potential to improve driver behaviour, reduce accidents and result in fairer determination of individual premiums based on individual risk.

4.7 Recommendations

- Use all available sources of information to formulate evidence-based decisions;
- Use the information to assist professionals to utilize best practices; and,
- Develop an annual public report that can be used to improve driver behaviour to reduce collisions and result in a fair method of determining individual premiums based on individual risk.

5.0 Summary

This document was prepared by the leadership of the Ontario Psychological Association to address the following issues:

- The Licensing of Business System and Business Practices of Service Providers;
- The Development of the Minor Injury Treatment Protocol;
- The OPA's Support for the Implementation of a Cost and Rate Control Strategy for Auto Insurance; and,
- The Enhancement of Auto Insurance Information and Analysis.

We believe that our recommendations are sound and will assist the Ministry of Finance to achieve its goals. The OPA is willing to actively participate in both the further planning of the Strategy and its implementation.

Reference Information

From the Frequently Asked Questions posted May 23, 2014

Why is FSCO using a fee based-approach?

Fees are the simplest, lowest-cost method of recovering the costs of service provider regulation.

Are fees proportional to the size and scope of the service provider's business?

Yes. Regulatory fees will vary by the size and complexity of a business. A small business treating few SABS claimants will pay proportionately less than a multi-location business treating many SABS claimants.