FSCO FIVE YEAR REVIEW

Suggestions for changes to the Statutory Accident Benefits Schedule:

The Two Tier System of Accident Benefits

It has become apparent that the issue of determining whether an injured person meets the definition of catastrophic under parts (f) and (g) has become extremely complex and expensive. The winners are the few doctors and lawyers who are expert in fighting with each other over the issue. We are asked to interpret an out-of-date and complex AMA Guideline. The actual drafters of the AMA guideline assure us that our cases are not being decided in accordance with their guideline, but this appears to make to no difference to subsequent decisions. It is not difficult for insurers to spend upwards of $100,000 in expenses on catastrophic determination. It would be far more responsible to have these funds benefiting a truly needy injured party.

Recommendations:

1. Remove the CAT definition from SABS in its entirety, while at the same time, reduce the med/rehab limit to a lesser amount for all claimants.
2. Alternatively, remove parts (f) and (g) from the CAT definition, but increase non CAT med/rehab limits to a higher figure, say $200,000. Consider also increasing the dollar and time limits for attendant care.
3. Alternatively, place dollar and assessor limits on CAT determination assessments.

PAF Guidelines

When the PAF system was introduced, we were told to expect that the majority of our claims would fall within the WAD I or II guidelines. Unfortunately, when we look at the data gleaned from our four months of HCAI use, only 9% (33/352) of requests for treatment came in via the OCF 23 form.

Recommendation:

1. Clinics submitting a high percentage of OCF 18 treatment plans on soft tissue injuries should be reviewed or audited by FSCO, and there should be penalties imposed on those that are found to be abusing the system.
2. Alternatively, set dollar/attendance limits on treatments for soft tissue injuries (such as those found in extended health care policies, the WSIB, or in other jurisdictions).

OCF 22

OCF 22 usage has continued to expand since it was first introduced. On claims where there is paralegal representation, and/or certain treatment facilities are involved, we often receive multiple OCF 22 forms. Most often they concern what appear to be uncomplicated soft tissue injuries. During our time using HCAI, the number of OCF 22's received was six times higher than the OCF 23's we received. Often the assessment or examination requested would be readily available and funded through OHIP by a simple physician referral (provided it was reasonable in the first place). In addition, the stress of attempting to meet the tight time frames and many, many apparently unreasonable requests has resulted in significant dissatisfaction in the accident benefit adjusting role and an industry wide staffing shortage in the accident benefit area.

Recommendations:

1. Limit the number and dollar amount of assessments available for soft tissue injuries, such as WAD injuries.
2. Require that a GP referral to a specialist, if applicable, is first attempted before the OCF 22 may be used.

SABS Time Frames for Insurer's Examinations

It is very difficult to meet the SABS time frames for setting up medical assessments. This is true for all involved parties, and is especially true when the insured lives in rural areas. For example, the insured person has only 5 days to provide the assessors with documents they would like considered. In addition, the stress of attempting to meet these time frames has resulted in significant dissatisfaction in the accident benefit adjuster role and an industry wide staffing shortage.

Recommendations:

1. Double the various timelines relating to the stages for medical assessments.
2. Allow notices to be sent via regular mail.

Suggestions for Other Related Areas -Dispute Resolution

Priority Regulation:

The 90 day time frame in which an insurer has to complete its investigation and notify a second insurer is too stringent. Unfortunately though, in most decided cases, the time limit has been strictly enforced. Issues such as dependency, and whether there is a spousal relationship, cannot usually be determined quickly, even with the cooperation of all parties. Insurers are often forced to notify more than one company "just in case". Once a higher priority company has been identified, there is no time limit in place for them to accept the claim even if they agree that they are priority. In addition, they will use the tight time frame to deny claims where they are clearly priority and absolutely no prejudice has occurred.
In addition, in many claims where we are sent an application, there is no insurer to be found, including us. We attempt to notify MVACF using this dispute process, but they deny that the above rules apply to them. There is significant delay and confusion about the process.

Recommendations:

1. Eliminate the 90 day notice requirement, or extend it, or reduce its status such that there is more time to complete a reasonable investigation.
2. Create a time frame for the higher priority company (including MVAC) to accept, once again with adequate time for it to conduct a reasonable investigation. Any unreasonable delay could be penalized through a special award at arbitration.
3. Clarify the definition of dependant for the purpose of determining priority by removing the financial aspect of the definition and making it dependency for care only (under 16, or a student living at home, or unable to care for themselves due to a disability).
4. Create a new definition of spouse for the purposes of priority only. Exclude those separated for a certain time period (six months or one year) from the definition of spouse.
5. Allow the transfer of reasonable claims expenses to the higher level company.
6. Ensure that the priority rules specifically apply to MVACF.
7. For ease of access, and consistency in costs, decision-making, and reporting, place responsibility for resolving disputes between insurers within FSCO.

Loss Transfer:

As with priority disputes above, it would make sense to have FSCO arbitrate disputes between insurer's over loss transfer.