OSLA The Ontario Association of Speech-Language Pathologists and Audiologists

July 9, 2008

Mr. Willie Handler
Financial Services Commission of Ontario (FSCO)
5160 Yonge St, PO Box 85
Toronto ON M2N 6L9

Submitted via email: 5YearReview@fsco.gov.on.ca

Dear Mr. Handler:

Re: 5 Year Review of Auto Insurance Regulations

Thank you for providing OSLA with the opportunity to submit our concerns and suggestions regarding the current auto regulations. We look forward to meeting with you on July 16, 2008 to discuss this document in person. We will bring the Appendices referenced throughout this document with us on July 16, 2008.

We will group our comments according to the categories set out in Superintendent Christie's stakeholder invitation letter.

AFFORDABILITY & AVAILABILITY

- Consumers must pay premiums for income replacement benefits – a benefit many can not access because they have disability insurance
  - **SUGGESTION: Make income replacement benefits optional if the consumer provides proof of alternative coverage; this will bring the premium cost down for many consumers**

- Most consumers are not aware of the option to purchase additional income replacement and medical-rehabilitation benefits
  - **SUGGESTION: Train insurance sales agents and brokers about the benefits of this extra coverage so more consumers would consider purchasing it (most agents haven't heard of the optional med-rehab coverage benefit); this adds a cost to the consumer, but it is an optional cost which adds to insurers' revenue and will help injured consumers obtain necessary rehabilitation should they require it; this is also another service that some insurers may choose to market to differentiate themselves on something other than premium price to help move the industry away from a sole focus on who has the cheapest premiums toward a "who offers the best value for money" focus**

- Insurers are making allegations of unfair and deceptive practices from some clinics – these clinics are apparently known to insurers, but are typically spoken about in general terms and used as a basis for extreme reforms that penalize good providers and drive them out of the system
    - **SUGGESTION: Make use of existing regulatory (e.g., health professional Colleges) and judicial (e.g., police and court) systems to eliminate these individuals/companies; this appropriately penalizes the guilty parties without painting all health professionals with the same brush and subsequently penalizing skilled, ethical providers; see Myths & Realities section below for further information**
    - **SUGGESTION: FSCO should issue a bulletin listing examples of inappropriate behaviour to make expectations very explicit**

- The FSCO fee schedule for speech-language pathology is well below market and government rates for our services, such that it has become difficult to attract and retain speech-language pathologists in this sector (see Myths & Realities section below), making it very challenging for consumers with the most complex injuries (i.e., brain injuries) to obtain services that are critical to their successful rehabilitation; even for those remaining in this sector, 28% report taking on fewer auto insurance clients now compared to just 2 years ago (Health Coalition survey, June 2008)
    - **SUGGESTION: Remove speech-language pathology from the fee schedule to allow natural market competition to develop OR eliminate the non-catastrophic rate for speech-language pathology services – see Appendix A for the letter sent on May 21, 2008 in this regard; these significantly below market value fees are the single biggest factor in drastically reducing the availability of speech-language pathologists in this sector, yet SLP services are known to be one of the most critical therapies for those with brain injuries to return them successfully to school or work (see Appendix B); in addition, the difference between net premiums written and claims incurred has increased six fold in the last 20 years (per IBC's "Facts 2008", page 11 – included as Appendix C), suggesting that the system is not in the dire straits some would have us believe**
    - **SUGGESTION: If the health professional fee schedule is to remain in place, fee schedules for other providers in the insurance industry (e.g., outsourced adjusters, private investigators, surveillance, insurance brokers, lawyers, etc.) should also be implemented that reflect a similar 30% cut to market billing rates with a similar non-catastrophic versus catastrophic differential; this will reduce costs to insurers which they can then pass on to consumers with reduced premiums, and will no longer unfairly and inappropriately make health professionals the scapegoats for costs in the system**

CONSUMER PROTECTION

- Newly injured consumers are overwhelmed with the complexity of navigating the insurance benefits system, resulting in one of two things – either they go without treatment for too long, which results in extended rehabilitation time, or they turn to a lawyer to help them manage the process
    - **SUGGESTION**: **In addition to allowing case managers for those who are catastrophically injured, allow case managers for those who are non-catastrophically injured for at least the first 6-12 months after an accident; this would ensure earlier and more effective treatment, which will reduce long-term rehabilitation costs, and will also reduce legal fees**

- Insurance adjusters often are not familiar with managing claims involving brain injuries, so in addition to the daily struggles these consumers with brain injuries face, they are put at particular disadvantage by adjusters who do not understand their cognitive-communication deficits and so expect them to be able to comprehend and respond to insurance information and procedures the way those with orthopaedic injuries would
    - **SUGGESTION: Create a "satisfaction survey" specifically for individuals with brain injuries and their families to rate the performance of their adjuster/insurer and then require adjusters to provide claimants with a one-page summary of their areas of claim adjudication expertise along with their satisfaction ratings; this would provide an incentive to insurers to develop some important expertise among their adjusters and would also allow consumers to "veto" the assignment of an adjuster who is not skilled in managing consumers with brain injuries**

STATUTORY ACCIDENT BENEFITS SCHEDULE

- It is time-consuming, and therefore costly, to place the burden of coordination of benefits on the shoulders of health care professionals; in addition, this is requiring individuals who are skilled in health care provision to spend time on insurance administration, when adjusters are more qualified to manage this task
    - **SUGGESTION: Given that individuals may still experience non-accident-related impairments requiring private health care, and given that extended health plans typically have very low coverage for services (e.g., $500 per year for speech-language pathology services), simply remove the requirement to bill auto claims first to extended health carriers; this would create a clean system where auto insurers pay for accident-related goods and services and extended health insurers pay for non-accident-related goods and services**
    - **SUGGESTION: Given that the above will take time to implement, in the short term, have the adjuster collect the extended health**

information (including maximum dollar amounts, policy and other important numbers, etc.) and send to all involved health professionals when they join a file; extended health insurers should be required to remit payment direct to health professionals for such auto claims, given that claimants with brain injuries are not the most reliable individuals to manage financial information

- Some insurers attempt to require a signature on OCF-22s, which is not necessary (either clinically or per the SABS) and, if the health professional feels compelled to comply with the request, is very costly to the insurer
    - **SUGGESTION: Issue a bulletin explaining that the signature is not required**
    - **SUGGESTION: If the insurer is concerned that the claimant may not be aware of the OCF-22, they can call the claimant and/or claimant's family and ask them about it; they could do this on an "as suspected" basis or simply on a random basis; they could also ask the health professional to supply the documentation of their conversation with the claimant/family**
    - **SUGGESTION: Require health professionals to send a copy of their OCF-22 (and OCF-18 for that matter) to the claimant**

- Insurers are indicating that 3 days is insufficient to review an OCF-22
    - **SUGGESTION: Although 88% of speech-language pathologists (Health Coalition survey, June 2008) indicate that the 3 day timeframe should remain the same, OSLA can support increasing the turnaround time to 4 days if truly necessary; this increases the time available by 33% without significantly delaying the rehabilitation process; we would suggest that adjusters use this extra day to contact the individual proposing the assessment to answer any questions they may have to assist in their adjudication decision**

- Insurers are indicating that far too many OCF-22s are being submitted (although we have not seen precise examples of the frequency – we may be better able to provide suggestions for this area once this information is made public); we are assuming that multiple OCF-22s are being submitted due to different individuals referring to other professionals simultaneously (e.g., a hospital discharge planner refers to an occupational therapist at the same time as a lawyer does, so both submit OCF-22s without knowing of the other's existence)
    - **SUGGESTION: Allow one assessment per discipline per 6 month period; when a 2nd OCF-22 from the same discipline is sent to an adjuster, the adjuster should be able to deny it (without then going to an IE) and inform and show evidence to both the health professional and claimant that another assessment is already underway; should a claimant later want to change to a different therapist of that discipline, they simply have to provide consent for**

the first therapist to release his/her report to the new therapist and a new assessment does not have to be completed

- Insurers do not provide specific reasons for denying an assessment or treatment plan despite arbitration decisions indicating that they must do so (e.g., Do versus Allstate, "It is not a reason for a refusal of a benefit to merely recite the language of the *Schedule*. The insurer is also required to elaborate on the reason for its view that the treatment is not reasonable or necessary."), which results in a) too many plans being denied but then subsequently approved by the IE assessor, wasting time and money (e.g., speech-language pathologists report that more than 75% of their denied plans are approved by IE assessors [Health Coalition survey, June 2008]), b) leaving the health professional and claimant wondering what the insurer's concern was, so they could have potentially addressed it, and c) requiring more time on the part of the IE assessor when the review could be more focused in nature
    - **SUGGESTION: Require that insurers stipulate a specific rationale for requesting an IE, not just "not reasonable or necessary"; if they do not provide a specific rationale, the plan should be approved in full**

- Insurer examinations are time consuming, and therefore costly, due to poorly organized documentation; documents often arrive in no apparent order, with duplicate reports interspersed
    - **SUGGESTION: Develop and then mandate a document organization system for IEs (e.g., documents must be grouped by discipline and in chronological order within each discipline)**
    - **SUGGESTION: Strike a committee of health professionals to define what documents are most important for their discipline's purposes when completing an IE (e.g., speech-language pathologists typically do not need any physiotherapy or chiropractic records, but always need speech-language and psychology records); when an insurer requests an IE, they can then only send the documents needed by that discipline, greatly reducing the time required to review the documents**

- Single discipline insurer examinations are more costly than necessary and have extremely tight turnaround times because of the "middleman" IE company; there are also sometimes concerns with the expertise of individuals chosen to complete IE assessments
    - **SUGGESTION: For single discipline IEs, have the insurer contact the health professional association (e.g., OSLA) for a list of IE assessors who meet standards set by the association (e.g., OSLA is currently developing a list of minimum standards that must be met by SLPs wishing to be on an OSLA roster of SLP IE Assessors for the province); this would a) reduce the cost of insurer examinations because there would be no "middleman" fee added to the cost of the assessment, b) allow assessors the full 10 days to**

complete their report (versus the 3-5 currently allowed by IE companies), and c) allow insurers to have confidence in the calibre of their assessors by having access to each assessor's "qualification data" maintained by the association; insurers should be required to obtain an updated list once or twice per year and would be welcomed to submit any concerns they had about the quality of work completed by any SLP IE assessors

- It is difficult for IE assessors when they are not able to communicate with treating providers either a) at all, in the case of paper reviews, or b) until after the assessor has completed the assessment, in the case of in-person assessments; this results in poor information transfer which can reduce the validity and reliability of the assessment and/or the analysis of documentation and increase the likelihood of rebuttal responses
    - **SUGGESTION: Have the client consent portion on OCF forms (verbal or written for an OCF-22, written for an OCF-18) automatically allow contact between the IE assessor and the treating practitioner**

- Paper reviews are additionally challenging because the IE assessor is not allowed to speak with the claimant to confirm the concerns listed on the OCF-22
    - **SUGGESTION: Specifically allow IE assessors to contact the claimant**

- There is no penalty for missing many of the timelines related to the IE process for OCF-18s, resulting in lengthy treatment delays
    - **SUGGESTION: Determine the maximum length of time an IE should take (e.g., 35 business days after denial for non-cat assessments, 55 business days after denial for cat) and require that treatment plans be funded in full if this timeline is missed**

- When rebuttals are written, it is rare that the treating professional receives any response from the adjuster, which leaves the claimant and treating professional wondering how the adjuster came to their final decision
    - **SUGGESTION: Require that the insurer submit their own analysis and decision to the claimant and health professional comparing the rebuttal with the IE assessor's report and response to rebuttal and explaining their determination.**

- Many insurers ignore the payment timelines and interest charge requirements set out in the SABS for pre-approved services; while there are many penalties for claimants who do not meet timelines or correctly fill in forms, there are no real penalties for insurers
    - **SUGGESTION: Increase the late payment interest charge to 5% per month once payments are 60 days past due and add "withholding payment beyond the stipulated timeframe in the SABS" to the list of Unfair and Deceptive Acts and Practices**

- The ability to access taxi transportation to/from rehab appointments is not well defined in the SABS or uniformly applied by adjusters, resulting in some clients being transported to appointments and others not
    - **SUGGESTION: Make it clear in the SABS what transportation is available for clients who are unable to drive after their accident; in some cases, it is quite important for therapists to see clients at locations in the community or at the client's home, but in other cases it is reasonable and cheaper for the client to be seen in-clinic, but transportation is required for this to be a possibility**

OTHER ISSUES

- When something changes on a file (e.g., new adjuster, switch from non-cat to cat status), there is no standard way of informing claimants or health professionals, resulting in confusion and mis-directed form submission
    - **SUGGESTION: Require that adjusters notify claimants and health professionals within 2 weeks of any such change occurring**

- There are adjusters who tend to deny the vast majority of plans, in spite of treating provider and IE assessor information supporting the need for assessment and treatment; this results in significant and unnecessary stress on injured consumers, which negatively impacts treatment efficiency and efficacy; this also adds enormously to the total cost of assessments in the system
    - **SUGGESTION: As mentioned above, requiring a specific rationale from adjusters should help curb unnecessary denials, but for those for whom it doesn't, there should be a mediation/arbitration option where the mediator could impose a loss of license on the adjuster for a period of one year; in addition, there should be a limit to the number of IEs that can be completed (e.g., only 2 IEs per 6 month period)**

- No notice is given to claimants and their health professionals regarding the status of their med-rehab funds; this results in sudden discontinuation of services
    - **SUGGESTION: Require that adjusters send out semi-annual statements of remaining rehab funds; this will help health professionals plan collaboratively with the claimant and adjuster and will help injured consumers make more informed decisions (although admittedly this will be challenging information for individuals with brain injuries to digest)**

MYTHS & REALITIES

A lot of rhetoric is thrown around by various parties when attempting to lobby for their group's particular interests. We would like to take this opportunity to clarify some issues

as they pertain to speech-language pathology services.

Myth #1: There isn't actually a shortage of speech-language pathologists in the province and therapists are flocking to the auto insurance sector because it is so lucrative.

> **Reality #1: There is a definite shortage of speech-language pathologists in the province. While there are 20% more speech-language pathologists working in Ontario now compared to 5 years ago, this increase is nowhere near sufficient to meet demand. The provincial government has recognized this by greatly increasing enrolment in graduate programs for speech-language pathology. At the two main graduate training universities in Ontario, enrolment is increasing this year by 11.6%. At the University of Toronto, enrolment has increased from 16 students in 2001 to 45 in 2008. If there was an adequate number or an over-supply of speech-language pathologists, the government would not fund this dramatic increase in post-graduate openings. In addition, agencies that hire speech-language pathologists are finding that positions typically remain vacant for 6 to 12 or more months, a clear indicator of a supply shortage.**
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> **The movement of speech-language pathologists across sectors is actually toward public sector positions, not private practice. There are 2,492 speech-language pathologists in Ontario. Only 10% work in private practice, with only a small portion of this number working in the auto insurance sector. There has been no change in this figure over the last 5 years. However, there has been a 4% increase in speech-language pathologists employed in the provincially-funded preschool speech and language programs and a 7% increase in speech-language pathologists employed in the Community Care Access Centre sector. Speech-language pathologists are certainly not flocking toward the auto sector and indeed many are leaving it (e.g., 28% of speech-language pathologists surveyed are taking fewer auto sector clients in 2008 compared to 2006).**

Myth #2: Health professional colleges will not properly investigate and discipline individuals who are not behaving appropriately and ethically, so a separate system should be developed.

> **Reality #2: The College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO) has committed to fully investigating and appropriately disciplining individuals who have had complaints filed against them (see letter reconfirming this commitment in Appendix D). CASLPO indicates that they currently receive and investigate about 15 complaints per year. In the 14**

years CASLPO has been in existence, not one single complaint has been filed by an insurer. One investigation currently underway, which we will discuss during our meeting on July 16, 2008, highlights the veracity of CASLPO's commitment to this process.

Myth #3: Too much treatment is being provided.

Reality #3: In 2007, the Heart & Stroke Foundation released its "Consensus Panel on the Stroke Rehabilitation System", identifying practice standards based only on strong research evidence. These standards indicate that individuals with a mild stroke should receive therapy from their speech-language pathologist 2-5 times weekly. Those with moderate and severe difficulties should receive speech-language therapy a minimum of 5 times weekly. This is the frequency of therapy typically offered in hospital settings, funded by the Ministry of Health. While the impairments seen after stroke do differ from those seen after acquired brain injury, the research literature describing treatment frequencies and outcomes often has similar recommendations in these regards. In reviewing the typical frequency of therapy recommended by speech-language pathologists in OCF-18s, therapists are actually under-treating claimants with acquired brain injuries. When asked why therapy isn't recommended as often as the research suggests, there are 2 common answers: a) the insurer won't likely agree to fund it, and b) therapists do not have enough room on their caseloads to offer this frequency of therapy.

Myth #4: "Mild" injuries in particular are being over-treated.

Reality #4: Appendix E contains a summary of a published article regarding so-called "mild" brain injuries. There are many other such articles. When it comes to brain function, there really is no such thing as a "mild" disorder – anything that impairs someone's ability to think and communicate effectively or efficiently has devastating consequences. This is why speech-language pathologists find the catastrophic/non-catastrophic distinction to be so frustrating when it comes to brain injury. A slight impairment in someone's ability to process incoming verbal information makes it impossible to function in today's society. We are no longer a manual labour society, we are an information-based society. Information is largely verbal, whether spoken or written. Appendix F contains an article describing the enormous importance of cognitive-communication skills in today's society. As discussed above, even so-called "mild" injuries require speech-language intervention 2-5 times weekly. A mild brain injury is very

different from a mild muscle strain – the two should never be considered comparable.

Myth #5: When insurance funds run out, therapy stops.

Reality #5: This may indeed be the case if the client has no other ability to fund their services, because therapists, like any other worker in the province, are not able to work for free. However, in cases where the client's insurance settlement allows them to continue purchasing private services, many do. Speech-language pathologists work almost exclusively with individuals with brain injuries in the auto sector. These individuals typically have very reduced insight and decision making abilities, so unless there is a close family member or friend to help them manage their settlement funds, they may not realize the importance of continued therapy until it is too late and negative consequences have occurred (e.g., jail, hospitalization, social withdrawal, poverty, etc.). However, in spite of this lack of insight, many clients do choose to continue funding speech-language pathology services after they receive their settlement.

We will be pleased to elaborate or clarify any of the above at our meeting on July 16th. Participants from OSLA will include Justine Hamilton and Jeffrey Lear, Auto Insurance Committee Co-Chairs.

Sincerely,

Justine Hamilton
OSLA Auto Insurance Committee Co-Chair

Sharon McWhirter
OSLA President

Jeffrey C. Lear
OSLA Auto Insurance Committee Co-Chair