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Financial Services Regulatory Authority of Ontario
Auto Insurance Sector
25 Sheppard Avenue West, Suite 100
Toronto, ON M2N 6S6

Re: Health Claims for Auto Insurance (HCAI) System Review

Thank you for providing Insurance Bureau of Canada (IBC) with the opportunity to comment on Health Claims for Auto Insurance (HCAI) System Review consultation (consultation document). Please note that IBC worked closely with HCAI Processing on this submission and HCAI Processing will not be making an independent submission. Our commentary on the consultation document is below.

HCAI System Review Consultation Questions

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

   IBC agrees that there is value in exploring some or all of the elements outlined in the four proposed initiatives. There are dependencies and scope considerations to be evaluated in some elements of the initiatives and this is reflected in the feedback. We believe that several factors should be considered in assessing the priority of these initiatives, including:

   - The potential for initiatives with shorter work streams to deliver benefits more quickly;
   - The potential for initiatives to deliver operational process benefits and provide a source of new data for analysis;
   - The nature and extent of the work streams required to deliver the initiatives and the ability of stakeholders to adopt the changes;
   - Aligning the scope of the initiatives with HCAI's intended role and purpose; and
   - The availability of appropriate budgetary and personnel allocations on the part of all stakeholders including IBC, insurers, the med/rehab provider community and FSRA.

   Based on these considerations, our recommendations on the prioritization of each initiative are outlined below. We have also outlined elements noted in the initiatives that may be considered out of scope for HCAI.

Priority 1 - Initiative A (Prioritize Increasing the Number of Forms Transmitted Through HCAI)

IBC previously completed a strategic analysis of opportunities for HCAI enhancements and identified adding additional business-to-business Ontario Claims Forms (OCFs) to HCAI as a high priority. This would provide both operational process benefits for health care facilities and insurers and help fill claims data gaps. The proposed additional forms take into account the speed with which forms could be implemented and that deliver important new data to support claims adjudication, system analysis and reducing fraud and abuse.

We recommend to first introduce the standard invoice for attendant care services, followed by the OCF-19 (Application for Determination of Catastrophic Impairment). The Form1 is currently processed by HCAI and adding the corresponding invoice would provide a business process improvement for health care facilities and insurers that will ultimately benefit the claimant. Further, both of these claims forms contain data relating to more serious claimant injuries which are not available from any other source.

We recommend against adding the OCF-3 to HCAI at this time. The majority of the OCF-3 forms are completed and signed by general practitioner physicians. While adding it to HCAI would be beneficial, we believe that there should be broad agreement from the general practitioner population before this should be added to HCAI.

Finally, we recommend against adding the OCF-24 Minor Injury Discharge Report form, the final business-to-business OCF form, as doing so would provide limited value. Instead, we recommend restructuring the purpose and content of the form to include more objective findings and details. If this form is restructured as part of Initiatives B and C, it could become a future candidate for inclusion in the OCF forms processed by HCAI.

Priority 2 - Initiatives B and C (Revising Forms and Data-related initiatives)

The majority of the data processed and collected by HCAI is done through an OCF form. The OCF form, and the associated HCAI Guideline, specify the data formats and data rules that HCAI and HCAI users must follow. Initiatives B and C are closely linked and we recommend working on them in tandem to ensure the alignment and bundling of the changes, and to facilitate the adoption by the stakeholder communities.

This will require extensive involvement of multiple stakeholders to ensure that all stakeholder needs are considered. As the requirements must be fully defined and approved by FSRA before development can start, the consultation process for these initiatives can occur while development and implementation of the forms in initiative A are progressing.

As FSRA's role in the HCAI system is to issue the HCAI Guideline and approve OCFs, we feel that FSRA is best positioned to lead the form and data review process to obtain consensus with all parties.

Considerations for managing changes to OCF forms currently processed in HCAI

In addition to our comments above, we have several recommendations for managing any OCF changes to current HCAI forms:

- The current OCF-18, 21, 23 and Form 1, as specified in the HCAI Guideline, are mandatory forms to be submitted through HCAI. When changes are made to mandatory forms, there is no transition or pilot period from the old form version to the new form version. To ensure the successful adoption of the changes by stakeholders, appropriate lead time will be required for several stakeholders, including:

    - Health Care Facilities (HCF) that use a Practice Management System. This is approximately 2,500 HCF's, which collectively represent 70% of HCAI form submission volume;

    - Integrating insurers; and

    - Other downstream users of HCAI Data, such as the HCDB, FSRA, and Équité Association, among others.

- Bundling together changes when making changes to the HCAI-processed OCF forms to assure consistency among the forms and realize IT cost efficiencies for all stakeholders;

- When reviewing opportunities for form simplification, consider downstream implications for changes to existing data fields/formats, usability and value of the data for operational and analytical purposes. For example, avoid using free-form text fields where practical;

- As noted in our response to initiative A, if the OCF-24 is enhanced as part of the form review process, it could also become a candidate to be added to the forms processed by HCAI. Possible improvements include restructuring the purpose and content of the OCF-24 form to include more objective findings and details and utilize checkboxes like those featured on the OCF-3; and

- Finally, when additional forms are enhanced and added to HCAI, we recommend updating the process to require submission of the OCF-24 in conjunction with the OCF-18 to indicate if additional treatment is needed after the pre-approved $2,200 MIG Limit. This would provide insight into health care outcomes and indicate whether the patient improved or did not improve and support why they are now submitting an OCF-18.

<u>Priority 3- Initiative D (Prioritize Other Initiatives)</u>

We support continuing to look for opportunities to improve the HCAI system's operational effectiveness and support for the user community. The following areas outline HCAI's current training and support offerings and how HCAI ensures system availability.

Training and Support

To support HCAI's large user base of over 30,000 users, HCAI continues to invest in support and training through its HCAI Information website. This public website includes information portals designed for HCAI's two main user communities, health care facilities and insurers, a portal for Practice Management System Vendors, and a section for general HCAI Information. It also provides links to regulatory resources to facilitate ease of access to other relevant information.

The HCAI Information website supports user entities with multiple formats for information delivery, written material, audio/video, or presentation format and it is structured with paths for both the novice and expert user. HCAI utilizes multiple training formats for adult learners such as user manuals, quick start guides and topic specific paths. E-Learning videos provide a one-on-one training coach approach to assist in the understanding of how to complete OCFs. HCAI users are also provided with a link to contact a live support representative who can assist in addressing more complex inquiries.

In addition to HCAI's self-service website, all businesses enrolled in HCAI are required to specify their key business and technical contacts as part of the enrolment process. These contacts are utilized by to communicate important system related information and to raise awareness about upcoming system releases.

Additional training and support initiatives include:

- For the Integrating Insurer and Practice Management communities, HCAI currently has dedicated technical resources to provide support and updates to these groups;

- HCAI hosts town halls in advance of each release to ensure that stakeholders have an opportunity to ask questions on upcoming releases;

- Onboarding of approximately 50 to 70 newly enrolled health care facilities per month. New facilities are provided with onboarding material and are invited to attend a live webinar designed specifically for novice users getting started and to answer their questions; and

- As part of HCAI's commitment to provide online information and training material, the HCAI Information Website is currently undergoing a modernization to further improve user experience and this new site is targeted to go live in early 2025.

System Availability

HCAI's infrastructure and processes have been implemented to support HCAI's operational reliability requirements and has a long track record of stability and availability. Key areas supporting HCAI's operational reliability include:

- HCAI infrastructure is set-up with fault-tolerant redundancy;

- HCAI infrastructure is hosted in a secure high-availability facility;

- HCAI Processing maintains a secure Disaster Recovery environment in a completely separate location from the main production site with infrastructure that mirrors the main production environment;

- HCAI data is continuously updated between the production and Disaster Recovery sites;

- HCAI data is backed up on a scheduled backup cycle and backups are maintained at a separate secure location from the production site;

- HCAI Processing conducts an annual Disaster Recovery test; and

- HCAI Processing has a formal Business Continuity plan in place and is updated regularly.

Information pathway for HSPs/assessors

The last item referenced in this initiative is to create a pathway in HCAI for HSPs/assessors who are performing assessments for independent examination companies to monitor what is being billed in their name on HCAI. IBC supports discussing this idea in greater detail. We previously supported the piloting of the Professional Credential Tracker (PCT) proof-of-concept, the results of which were shared with FSCO, FSRA and the participating health regulatory colleges.

In its present form, the PCT proof-of-concept can only show the list of providers that clinics have entered in their HCAI provider rosters. If there were interest in funding development of the PCT as an ongoing operational tool for enabling providers to monitor what is being billed in their name on HCAI, a number of key decisions would need to be made, including determining what to build, how it will be operated and the associated funding requirements. In particular, enabling individual providers to access the system directly would be a significant undertaking, which would require agreement from the professional colleges to participate in validation processes to ensure that providers requesting access are who they say they are.

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

The OCF forms are a central vehicle for communication between Health Service Providers (HSPs) treating claimants injured in collisions and the insurers who pay the injury-related no-fault benefits in accordance with the requirements of the Statutory Accident Benefits Schedule (SABS). The forms must provide the information that insurers need to make informed decisions on benefit requests. At the same time, they must be easily understood by claimants and HSPs who use them. By virtue of the HCAI system for electronic transmission of key forms, OCF data is an invaluable source for analyzing trends and emerging problems whose ultimate effects are felt by injury claimants as well as drivers.

As noted above in the priority 1 recommendation, we believe that there is a substantial business benefit to expanding the classes of OCFs that are processed and invoiced through HCAI. It would provide both operational process benefits for health care facilities and insurers and help fill claims data gaps.

Regarding form and data review initiatives, we note several potential business benefits to reviewing and updating the forms, including:

- Improving the understanding of claimants' eligibility for benefits;

- Improving the claimant experience by reducing the need for health care service providers to request further information ; and

- Helping identify and reduce fraud.

As part of the form review process, we recommend that the OCFs collect enhanced data that provides more specific information on med/rehab goods and services, and use additional codification to permit data aggregation and analysis of important information that is currently conveyed as free-form text.

Other proposed form modifications address the need for better safeguards against non-compliance with regulator guidelines and misrepresentation of the services being provided. These include standardization of the reporting of time spent providing therapeutic services and of the type of health care provider (e.g., regulated health professional or associate) delivering the services.

Consultation reference regarding claimant access

The consultation paper references potential access by claimants to their billing information to help individuals monitor their claims. HCAI is designed as a business-to-business platform that contains only a subset of the individual's claim and it does not contain payment status information. Claimants would still be required to engage with their insurer to obtain claims status information despite potentially having access to HCAI. This creates an unnecessary duplication with insurers own roles and systems.

A healthy competitive landscape is in the interests of Ontario consumers, and this is best achieved by leaving claims management/tracking in the hands of insurers, who can innovate and compete to provide the best possible service. For this reason, we believe that insurers remain the appropriate party to service and inform their claimants regarding the status of their claim and this role would be outside of HCAI's mandate.

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

The consultation document outlines several topics raised by other stakeholders. We offer the following responses to several items raised by stakeholders.

<u>Coding</u>

The stakeholder feedback suggests that the data fields and codes used to submit information are outdated and that HSPs should be engaged to review codes to ensure that they are updated with the necessary specificity. There is additional stakeholder feedback that more education and guidance should be provided on HCAI, including use of codes.

With respect to the coding, as part of the original consultations for the development of HCAI, stakeholders agreed that the CIHI (Canadian Institute for Health Information) codes would be used as primary code set in HCAI. HCAI uses standard CIHI coding on OCFs for injuries (ICD-10-CA) and interventions (CCI). CIHI provides a major version update every three years and HCAI schedules code updates to align with that schedule. HCAI currently utilizes the 2021/2022 version of the codes, which is the current available version. Given that CIHI is the owner of these codes, we note that HCAI is not authorized to modify the codes in any way. Further, as the codes are licensed property of CIHI, the codes (or a subset of codes) cannot be displayed on the publicly available HCAI Information Website. The health care facilities that are treating patients are in the best position to understand the nature of their client's injuries and recommended treatment, and the associated CIHI codes to use to describe the injuries and treatment.

HCAI also utilizes Goods, Supplies, Administration (GAP codes) for goods/supplies, coding for unit measures and coding for provider types. GAP codes used by HCAI were developed by IBC in conjunction with automobile insurers and health care providers to cover those items billed to automobile insurers by providers that are not covered by the Canadian Classification of Health Interventions or may be more efficiently coded using the GAP codes.

HCAI does include some training on the HCAI Information website regarding the standard codes HCAI uses, and the basics of injury and intervention coding. The industry is supportive of reviewing the coding to identify opportunities to streamline the business processes, improve data integrity and efficiency of the auto billing system and to reduce the potential for fraud. There are limitations, as noted above with respect to the CIHI codes. However, the GAPs codes and unit measures are areas where there may be more opportunities for improvement as part of the review process.

This initiative will not only protect the integrity of the auto billing system but also ensure that resources are utilized effectively.

Health Outcome Measurement

We support the introduction of a standardized, reliable and verifiable health outcome measurement (OM) method as part the med-rehab component of the Ontario auto insurance system. Among the benefits of OM is its potential to shift health care to a patient-centered focus. This is, in part, because it serves as an incentive for quality rather than quantity of care. Over time and through analysis of the OM data it can also be a tool for comparing the effectiveness of different types of therapeutic interventions.

At the same time, the industry recognizes the challenges of bringing OM to Ontario's auto insurance system. The auto insurance framework is very different from single-payer, large institutional settings such as WSIB and OHIP where the use of OM has demonstrated value in promoting patient recoveries and in supporting the efficient use of medical resources. Given that most scales of pain or impairment are self-reported, consideration will need to be given to finding the appropriate and reliable measurement tool. The OM program for the insurance space will require careful design to ensure meaningful results. If there is interest in developing and implementing a mandatory health outcome measurement and reporting program, we recommend that FSRA be aware of several considerations:

- The process will require time to permit extensive consultation between the insurer and HSP communities on a variety of key issues:
    - Identify stakeholders to participate in the consultation process
    - Involve health science and subject matter experts in the process in order to bring evidence-based knowledge and discipline to this initiative
    - Secure funding for the health science and subject matter experts

- Achieve agreement on a choice of OM tool(s) that can be used with confidence by multiple health professional groups providing medical services for a widely diverse population where a similarly wide range of injury configurations is present;

- Determining the method for reporting OM information from the selected tool(s). HCAI could be considered as a method for submission and collection of OM data;

- Time will also be required for implementing the OM system, including time for required regulatory changes, relevant IT system and process changes, as well as for training of all parties; and

- Defining governance process for managing the OM implementation and project and determine the entity that will be responsible for carrying out system-wide analysis of OM data.

As noted above, HCAI could act as a method for submission and collection of OM data. However, we note that embedding meaningful outcome measurement and reporting in the insurance medical rehabilitation system will require significant multi-year commitments of time and resources from relevant stakeholders and FSRA.

Claims Disposition data (data between insurers, claimants and their legal advisors)

IBC understands the desire to have comprehensive, system-wide data on accident benefits claim dispositions and durations. Some accident benefits claims are settled through cash settlements negotiated between the parties while others remain open for extended periods of time. This can be the result of extensive litigation around the claim, the claimant waiting for the outcome of a companion tort claim before settling the accident benefits claim, an injury claim involving a minor child that cannot be settled until the injured person reaches majority age, or a claim simply lying dormant before again becoming active years later. Still other claims may close only to be re-opened at a later date. Because of these various factors, there does not exist a reliable methodology for consistently reporting when claims are closed.

The vast majority of activity leading up to claims settlement and/or closure happens outside of the HCAI-enabled interaction between insurers and HSPs around the submission of and response to specific benefits requests. The settlement process is the core responsibility of insurers, claimants and their legal representatives.

For these reasons, we do not recommend that HCAI be considered for reporting claims disposition data.

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

In addition to the items noted above in the responses to questions 1, 2 and 3, we recommend that FSRA consider the following:

- For the benefit of all stakeholders, need a clear confirmation of the approval process for each initiative;

- Supporting change management, communication and training strategies for regulatory, business and IT components will need to be developed;

- Consultation requirements and timing can vary for each initiative;

- Requirements must be fully defined and signed off before development can start;

- To ensure successful adoption by stakeholders, appropriate lead time must be allocated for required IT changes, process changes and training. Lead time requirements will vary depending upon the complexity of the initiative;

- New forms should initially be introduced on a minimum one-year pilot basis;

- Implementation of changes to existing mandatory forms may require extended development and lead time requirements as there is no pilot or transition period for mandatory forms; and

- Consideration on how the upcoming Ontario auto insurance reforms regarding optionality may impact timing of the initiatives and the OCF forms.

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

   The approval process for each initiative needs to be clearly defined. As the approver of the OCF forms and issuer of the HCAI Guideline, we recommend that FSRA leads the consultation process with relevant stakeholders.

   We recommend that FSRA lead the initial communication activities to announce the approved initiatives and the associated consultation process. Once initiatives that are applicable for HCAI have been approved and requirements signed off, HCAI will commence its standard system release change management and communication processes for its insurer and health care facility user base.

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?*

   As a longer term consideration, following the implementation of additional business-to-business OCF forms and the review and update of current OCF forms, we recommend that FSRA consider utilizing HCAI to collect business data beyond that collected via the OCF submission and adjudication process. Some examples of data that could be considered include:

   - Health outcome measurement data;

   - Insurer examination results; and

   - The incorporation of health regulatory college data into HCAI to support provider identity validation.

Thank you again for the opportunity to comment on the Health Claims for Auto Insurance (HCAI) System Review consultation. If you have any questions please don't hesitate to reach out.

Sincerely,

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AD/jw