November 15, 2024

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

RE: Consultation Paper – Statutory Accident Benefits Schedule (SABS) Guidelines Review (PSG)

Introduction

I am writing to you today as a CEO of FunctionAbility Rehabilitation Services group of companies. By way of context, the FunctionAbility group includes three distinct companies: FunctionAbility Rehabilitation Services, Social Work Consulting Group and Entwistle Power Occupational Therapy Inc. In this submission I will refer to the group as FunctionAbility.

FunctionAbility is a leader in rehabilitation for clients who have suffered severe traumatic injuries. We have been in business for over 20 years and employ over 300 staff members representing 7 clinical disciplines. Our services are delivered across Ontario and British Columbia. Approximately 90% of our business is Ontario based. We service multiple payer systems including: Auto Insurance, WSIB, WSBC, VA, ICBC, LTD, HCCSS and private (self-pay) clients.

Within Ontario's auto insurance sector, we service non-CAT and CAT clients (we do not service MIG), and provide our services to both PPN and non-PPN clients across the entire province of Ontario.

Our long track record and business mix allows me to have valuable insight into compensation of clinicians, across multiple provinces, various payer systems and different clinical disciplines. It also, allows me to have intimate knowledge of the challenges related to supply/demand of healthcare professionals, scope of practice across different payer systems, and associated indirect costs.

These insights give me a wide lens viewpoint into the topic of Ontario's auto insurance Professional Service Fee Guideline (PSG). *From this unique vantage point, I can unequivocally say that the PSG is significantly under market and must be urgently increased by cumulative CPI since 2014.*

Intent of Insurance

It is important that as we embark on the analysis of the matter at hand, we start from first principals and identify the original intent of Ontario's Auto Insurance product.

Generally speaking, the intent of our AB system is to ensure that accident victims have access to necessary medical treatment to help recover from injuries or manage consequences of an accident without going through lengthy litigation. This is of particular importance in Ontario, where most people assume that all healthcare costs are

covered by the publicly funded system, but in fact, rehabilitation services (outside of inpatient facilities) are largely not covered under OHIP.

This is echoed by the Insurance Bureau of Canada which on its website states that "Auto insurance coverage provides protection for personal injury and property damage".

It is not surprising then that the SABS includes an entire section titled: "Responsibility to Obtain Treatment and Participate in Rehabilitation".

Further, receipt of healthcare services in the aftermath of injury is also in alignment with FSRA's objective of "protecting the rights and interests of auto insurance consumers".

According to the above, then, receipt of healthcare services is: a) the intent of the insurance system; b) explicitly written into the SABS; and 3) is a central right of insurance consumers. As such, access to healthcare must be a central consideration. Since there is significant competition for very limited number of providers, compensation for services must be competitive to maintain access and availability of healthcare services.

The Supply-Demand for Healthcare Professionals

The supply-demand for rehabilitation professionals in Ontario can be described as grossly out of balance. The analysis below does not attempt to address all professions but rather only the regulated RHP's that we have intimate knowledge of and provided by FunctionAbility in Ontario. It covers the period starting in 2014 which is when the last adjustment to PSG was provided.

The Supple side:

The following table reflects the growth in rehabilitation RHP's along with supply per 1,000:

Discipline	Annual growth rate 2014-2022	Supply per 1,000 population
Nurses	1.5%	12
Occupational Therapists	3.3%	<1
Physiotherapists	3.8%	<1
Speech Language Pathology	2.5%	<1
Social Work	3.1%	<1

Source: Canadian Institute for Health Information (CIHI)

Supply of rehabilitation professionals is highly inelastic because they are dependent on the number of university admissions which are, in turn, not increasing fast enough. Further, all rehabilitation professionals are master-level education, meaning that the process takes at least 5-6 years. Even if admissions were to suddenly increase, the timeframe to feel the increase in supply will take many years.

The above figures tell a partial story. This is because they only capture the period up to 2022. As has been well publicized, many healthcare providers permanently left their professions as a result of burnout during COVID. This has reduced supply further.

Demand Side:

- According to StatsCan Ontario's population grew by 18.6% since 2014.
- According to StatsCan Ontario's senior (65+) population, being a major consumer of healthcare, grew by 40% since 2014.
- According to a CBC article published in May 2024, which is based on government analysis, Ontario is projected to need "thousands of new nurses and PSW's by 2032".
- According to Globe & Mail May 2023 article Ontario is "facing a crisis as a result of shortage of rehabilitation providers".
- Federal government has expanded the rehabilitation services provided through its VA program.
- Ontario's government increased its budget and breadth of services provided by both hospitals and home healthcare.
- Offering to aboriginal communities, which includes many rehabilitation services, has been expanded.

All of the above have placed massive pressure on demand for rehabilitation professionals.

The table below brings to life the significant demand for professionals. It reflects an analysis which compares demand for the professions (calculated as the percentage of open positions advertised on the job site Indeed in Ontario, divided by total practicing professions), and compared to the annual growth rate in each profession as per CIHI.

Profession	**Open advertised positions on Indeed vs total registrants**	**Estimated total percentage of open positions***	**Annual growth rate in profession**	**Demand/Growth in Supply**
Nurses	7.5%	15.0%	1.5%	10.0x
Occupational Therapists	8.1%	16.2%	3.3%	4.9x
Physiotherapists	6.6%	13.2%	3.8%	3.5x
Speech Language Pathology	6.2%	12.4%	2.5%	5.0x
Social Work	10.4%	20.8%	3.1%	6.7x

*Total market estimation based on Indeed represents 33% of job board market share but adjusted to some entities advertising on more than one job board.

It is evident from the above that demand from advertised positions on Indeed alone significantly outstrips supply by a range of 2:1 to 5:1. Actual estimated shortage is in the range of 3.5:1 to 10:1.

It has been noted in both FSRA's consultation paper and verbal presentation that "FSRA has received stakeholder feedback that suggests most consumers are able to obtain the care they need from health service providers under the existing fees/rates found in the Professional Services Guideline (PSG)". With respect to this statement, clarification has been requested about which "stakeholders", what "feedback" and quantification of "majority". No information has been provided. Critical decisions must be made on the basis of clear data such

as the supply-demand disparity outlined above, rather than anecdotal feedback by some self-interested and conflicted "stakeholders". I would also like to point out that "majority" technically means 51%. If true, and only half of claimants are able to obtain care, the system is in very serious trouble.

Consequences to Lack of Adjustment to PSG

Now that we have established the dramatic manner in which demand for rehabilitation professionals outstrips supply, I will move to describe the existing and future consequences of continues PSG rate freeze.

Since the last PSG adjustment a decade ago, we have seen significant expansion in demand for rehabilitation services across all payer systems in Ontario. The preceding section established that there is both a low number of rehabilitation professionals and that annual growth in new graduates entering the market is quite limited. As is always the case when demand outstrips supply, labour starts to move into higher compensation opportunities. As this occurs, availability in lower paying systems starts to decline.

The above problem became exacerbated in early 2020 as a result of the intersection of: a) many professionals leaving healthcare as a result of COVID-related burnout; and, b) rapidly escalating inflation. The contraction in labour force led to a fiercer competition for professionals, while at the same time rapid inflation necessitated providers to seek out higher paying jobs to keep up with cost of living increases.

The response to the above was a review of compensation/pay-rates across almost all payer systems. During that time, we saw rate reviews completed, and increases awarded by the hospital sector, public homecare, WSIB, VA, ICBC, WSBC. Rates for private services also increased significantly. Such reviews continue to take place with the latest being an increase awarded to the OMA.

The one glaring exception to the above has been the continued resistance to review the PSG. This is despite numerous appeals to FSRA (FSCO before) and Ministry of Finance, by many stakeholders. It is noteworthy to point out that while ignoring healthcare workers' requests, policy premiums charged by insurers were allowed to increase by over 34.5% over the same timeframe. The approved premium increase for insurers was coincidentally more than same-period CPI of 28.9%. The most cited reason for insurers' request for premium increases has been "inflation", which is understandable. What is perceived as a grossly unfair double-standard, is FSRA's acquiescence to insurers' request for increase, but refusal to even consider the same request made by healthcare providers, all while regulating both sectors.

Consequently, both professionals, and employers began to shift work towards higher paying systems outside of auto insurance. While I am aware of many similar examples, I will note that my own company has prioritized growth in all payer systems, at the expense of shifting resources away from auto insurance. That is, we have been aggressively pursuing non-auto-insurance work. Due to limited supply of clinicians, we shifted our efforts to meet demand outside of auto insurance.

While the process of shifting work to new systems can be slow (i.e. one needs to wait for RFP's to emerge), this has been steadily happening over the past decade. Again, using my own company's experience as a proxy, I can say that our auto-insurance work has shrunk by 25%, while other payer system representation grew by 75%!

The above means that less services are available for motor vehicle crashes. While the auto-insurance sector has always been lacking in data, I can say that anecdotal evidence supports the fact that services have become increasingly scarce for auto insurance claimants. The simple evidence is that my own company is receiving an increasing number of inquiries from insurers to join as a PPN provider. This is not due to an increase in the number of claims (since those have actually declined) over the past number of years. Rather this is because, existing vendors are also diverting resources outside of this sector and insurers are trying to backfill the vacuum.

The sector is already in trouble. However, if urgent course correction and fair increase to rates is not implemented the situation will become dire. The consequences of continued exit of providers from this sector will lead to:

- Significant delay in treatment of severely injured claimants;
- Increased risk of re-injury;
- Setting-in of chronic conditions;
- Delay in return to function (i.e. return to work);
- Increase in insurer cost for other benefits such as attendant care, IRB etc;
- Increased litigation;
- Increase in quantum of tort settlements; and,
- Increase in shifting of costs from private insurers to public sector both in terms of healthcare costs (i.e. more re-injury, hospitalization, more pressure on primary care) and social services (due to inability to return to work).

In fact, all of the above will ultimately lead to higher costs which will outweigh any increase to providers' rates. Conversely, there is much literature that speedy access to appropriate healthcare leads to decreased insurer costs.

Perhaps worst of all, the system will fail to meet the very basic premise for its existence. That is, providing claimants with care in the event of injury, as outlined at the beginning of this paper.

Rate Survey

It is of little surprise then that as demand outstrips supply for rehabilitation professionals, many payer systems needed to improve their competitiveness by increasing compensation.

Consequently, we have seen increases in rates across WSIB, VA, WSBC, ICBC, hospital sector, home healthcare.

The table below compares Auto Insurance PSG rates to rates offered by other payer systems:

	MVA/PSG	WSIB	LTD	WSBC	ICBC	Private	Association	VA
PT	$99.75	$93.10*	$140-$150	$120	$145	$130-$145	$140	$120
OT	$99.75	$152.07	$132-$155	$127	$136	$130-$150	$150	$140
SLP	$112.22	$93.10*	$190-$205	$140	$140	$150-$160	$207	$120
SW	N/A	$139.00	$160-$245	$140	$140	$175-$225	$150	$200

*Actively being reviewed for increase by WSIB

The table above attempts to make an apples-to-apples comparison by accounting for the following:

- The PSG includes a higher CAT, however, those injuries represent roughly 0.5% of total claimants. Thus, the non-CAT rate is more relevant for this comparison.
- There may be multiple codes available for each discipline under a given payer system. This analysis selected codes that are similar in scope and complexity to the work done with auto insurance claimants. This is a crucial point when conducting analysis.
- WSIB is actively in the process of adjusting its rates. Rates that have not yet been reviewed include SLP, PT.
- "Association" column refers to rates recommended by the professional associations for each discipline. They do not update their recommendations frequently and in some instances those are several years old (yet still higher than current PSG).

I would like to caution that it may be possible to find rates that are lower, but that does not mean that it is representative (or similar in scope). It is likely an indication that the rates have not yet been reviewed and that access to services is likely exceptionally difficult.

Additional Factors and Considerations Unique to Auto Insurance

As you embark on adjusting the outdated PSG rates, the following factors must be also considered in the context of delivering services within Ontario's AB system:

a. Since the last PSG adjustment in 2014 CPI increased by 28.9%.
b. Hourly rates governed by PSG are meant to be all-inclusive and hence also cover overhead costs which have dramatically escalated since 2014 (CPI is also a good peg here).
c. Comparable rates from other payer systems are higher;
d. Scope of work: Not all work delivered by healthcare providers is the same. MVA work is quite complex in nature as its scope is wide in comparison to other payer systems. For example, WSIB only deals with return to work goals, LTD deals with addressing specific conditions, while MVA deals with all of the above and return to overall function. That is, providers who work with MVA clients must be versed in assessment for attendant care, equipment, hospital discharge, physical health, mental health, function in the community, in school, at work, return to work etc. Thus, wider scope translates into higher and more expensive skill-set. It also requires continued investment in more training, which further increases costs.
e. Volume of work: Non-auto insurance payer systems award volume contracts. Volume contracts result in some economies of scale. There are no such volume guarantees for all service providers in the auto insurance sector, other than PPN providers. Low volume work is hence priced at a premium.
f. Auto Insurance legislation and landscape is very complex and requires additional staff training and oversight costs not present in other payer systems.
g. FSRA licensing system is complicated and leads to additional costs not present in other systems. These costs include:
    i. Annual fees
    ii. Compliance costs
    iii. Other costs such as the need for licensed providers to pay out of pocket for prescribed unlicensed services and then seek for reimbursement.
    iv. Costs associated with working on HCAI as a separate system or integration costs into PMS.
    v. Costs associated with following-up on EHC.

vi. Very difficult and acrimonious relationship with adjusters. Frequent denials leading more administration costs and clinicians often working for free.

Recommended Increases

Based on the preceding analysis I recommend the following rate increases:

Discipline	2014 Non-CAT	Recommended Non-CAT	2014 CAT	Recommended CAT
Occupational Therapy	99.75	$130.00	$119.92	$150.00
Physiotherapy	99.75	$130.00	$119.92	$150.00
Speech Language Pathology	112.22	$145.00	$134.17	$167.00
Social Work (MSW)	N/A	$145.00	N/A	$165.00

Minimal Effect of PSG increase on Premiums

An often-cited reason to not raise the PSG is its potential effect on premiums. The following table calculates the effect of a 29% increase in healthcare costs (i.e. 29% increase in PSG rates). The following figures are based on fully matured 2019 date-of-loss and pertain to items impacted by PSG (including both treatment and IE provider costs):

(in millions)	
Non-MIG Treatment	$ 158
50% MIG/Non-MIG	$ 128
Provider Initiated Exam	$ 156
Insurer Initiated Exam	$ 46
Transportation	$ 4
Total Costs Subject to PSG Adj	$ 492
After CPI 29% increase	$ 635
Less: existing limit policies	$ 21
Net Projected Cost	$ 614
Net Increase	$ 121
Number of policies	8.2
Total Annual Increase/Policy	$ 14.8
Monthly equivalent	$ 1.23
Average Policy	$ 1,927
Percentage Increase	0.77%

Source: HCDB database and GISA

The table above calculates that a 29% increase (cumulative CPI since 2014) in healthcare costs across the board will translate into only $1.23/month increase to average premium (or 0.77%).

This means that to raise PSG rates by total CPI since last adjustment in 2014 will increase premiums by only 0.77%. This is a fraction of the 34.5% increase that auto insurers were permitted to raise rates over the same period.

FSRA's consultation paper makes mention of an optional indexation benefit. In short, this is a terrible idea both because it is complicated for consumers to understand, and because the impact of future CPI increases on premiums are negligible. If a 29% PSG increase leads to only 0.77% increase in premiums, then an annual CPI increase will be negligible. This is reinforced by actuarial reports that show healthcare as not being a cost driver in auto insurance.

Consultation Questions

1. *If PSG rates are indexed, what should they be indexed to?* CPI is the easiest and most available index. Indexation should be cumulative to the last increase in 2014.
2. *If PSG are moved to flat rates, how should those be determined?* As discussed in following section, flat rates in the context of non-CAT/CAT injuries are not viable.
3. *Should rate increases be staggered incrementally or over a few years?* A onetime increase as recommended above is needed immediately. It cannot and must not be staggered to prevent continued exit from the sector. A decade-long freeze has already been too long.
4. *Should FSRA review rates and at what frequency?* Rates should be indexed to CPI, adjusted annually and reviewed every 5 years.
5. *For Option C how often should insurers/HSP meet to review set maximum rates?* Option C should not be pursued.
6. *Do you have any evidence that consumers are having difficulty obtaining the HSP care they need due to the existing PSG rates?* I do not have industry-wide data for the entire sector. Lack of data in this sector has been frequently flagged as an ongoing problem by stakeholders. However, I can offer the following, based on personal experience: a) My company has clear data with respect to decreasing number of job applications for our auto insurance recruitment postings, along with declining offer acceptance rate. The difference is dramatic as compared to our successful recruitment for other payer systems; b) There is a rapidly growing Plaintiff Lender sector in Ontario. Much of the borrowing by victims is directed towards healthcare; and c) My company has redirected resources from auto insurance sector to other payer systems; d) I am aware of multiple competitors who have cut back, or existed the auto insurance sector altogether.
7. *What are the key implementation considerations that must be taken into account*? In my opinion Option A (Indexation of PSG) is the only viable path forward. One of its benefits is that it is also the easiest to implement. While the adjustment should be processed urgently, all other systems are already in place. All that needs to be done, is to update the HCAI system effective date of increase.
8. *What are key implementation considerations*? Urgency for increase is very high. FSRA must act as soon as possible.

Additional Associated Considerations and Recommendations:

1. I recommend maintaining a separate special rate category for CAT designated clients. The care required for

those claimants who are most severely injured is very complex. Clinicians that possess such high-level specialized skillsets are rare and in exceptionally high demand. As such, this category must be maintained.

2. There is currently no rate under PSG for Social Work. This discipline is critical for claimants, many of whom suffer from mental health impairments after traumatic car crashes. With almost non-existent availability of psychologists, the load for treatment falls on Social Workers. The current absence of a set rate under PSG is leading to many disputes between insurers and providers of Social Work services (50% in our experience). Adding Social Work (MSW level) to PSG will address many current disputes.
3. Increase of hourly rates will translate into less time being available for assessments if the $2,000 cap remains in place. I generally recommend that the $2,000 cap be scrapped. However, if not then it must be increased to ensure that the time allocated to assessments is not reduced.
4. The existing PSG is confusing as it refers to the rates sometimes as being minimum and sometimes as being maximum. When drafting the new PSG, clarify that the posted rates are both maximum and minimum.
5. *There is mention in the consultation paper of claimants paying out of pocket.* It is difficult to say what context this comment is made in. I will say that out-of-pocket pay is only *sometimes* done in the context of Extended Benefits. The presumption there is that Extended Benefits are delivered for minor needs and as part work benefits (meaning that a person has associated income to pay). This assumption cannot be made in the context of PSG. That is, PSG applied to claimants who sustained severe injuries that are complex to treat, and many claimants have been previously unemployed so the presumption of out of pocket pay is a non-starter.
6. *The consultation paper notes that an increase in rate will result in less service hours.* While this is true from a pure mathematical perspective, the following should be noted: a) continued rate freeze will drive providers out of the sector resulting in no services available (i.e. slightly less services is still better than no services); b) appropriate rates will attract high skilled clinicians who will improve outcomes and in fact reduce the number of hours required to treat a given claimant.
7. *Consumers to whom the PSG is applicable do not reach cap limits and as such contribute to increases in cost.* This is untrue. Many non-CAT claimants routinely reach cap limits.
8. *Increase in PSG will increase premiums which conflicts with other policy goals relating to minimizing increases*. Yes, an increase in PSG may lead to a negligible increase. However, as previously illustrated in this paper, such increase is less than 1% and highly unlikely to be felt by consumers. The comment is also viewed as an unjust double standard, in the sense that it is perceived to be acceptable to not award healthcare provider fair adjustments, while at the same time approving 34.5% increase in rates charged by insurance companies over the same time. If premium increases have been a concern, why were insurers not made to freeze their rates for a decade?

<u>Other PSG Options (B-D) that should not be pursued:</u>

- Option B - Move to Flat Rate Fees: This might be an acceptable option for routine minor and uncomplicated injuries (such as MIG) where standard programs of care can be formulated. However, PSG applies to claimants outside of MIG. Injuries outside the MIG are complex in nature. As noted by Dr. Cote, they cannot be standardized. Rather, treatment plans for such injuries are prepared on a custom, case-by-case basis. This is the precise reason that other payer systems don't use flat rate fees for complex conditions. For the same reasons this will not work within the context of non-CAT and CAT injuries of car crashes.
- Option C - Do not Prescribe Rates: Lack of prescribed rates will lead to staggering number of disputes. Social Work is a case in point. This rate is currently unregulated within the PSG and subject to

numerous disputes. In our experience 50% of all Social Work treatment plans are denied based on a rate disagreement (which in our case is at the low end of the market). The fact of the matter is that insurers are conflicted between their obligation to claimants and shareholders. The above is precisely the reason that it was the insurers who requested the establishment of the PSG in the first place. Existence of the PSG allows delivery of services on expedited basis to seriously injured clients without delays for fee negotiation. It also allows for predictable cost budgeting and claim provisions for insurers. This is the reason that a version of the PSG is present in virtually every payer system (WSIB, VA, WSBC, ICBC etc).

- Option D - Status Quo, Maintain Existing Hourly Rates: the reasons against this option have been covered in length in this paper.

Conclusion

A decade-long neglect of healthcare providers working in the auto-insurance sector has led to erosion of available services. The trend of providers exiting the system is underway and expected to worsen as most other payer systems have increased rates to keep-up with overwhelming demand for clinicians. The ongoing lack of service availability will have a significant and long-lasting impact on Ontario's drivers.

As has been illustrated in this analysis, the shifting of providers from one payer system to another does take time. This has worked in favour of the auto-insurance industry so far, as it delayed visible impact of the decade-long freeze. However, we are now at an inflection point where significant cracks are showing. Immediate action is necessary to tip the balance since, as long as it took for providers to move out of the system, it will also take equally long to move back in. This is because providers which moved out of the system are subject to multi-year contractual obligations.

To that end, I call of MOF and FSRA to immediately increase rates for the disciplines listed in this submission by cumulative CPI since 2014. Two years ago, healthcare providers were called "heroes". Heroes don't deserve to be abandoned by its government and regulator.

I invite you to reach out to me with any questions at nick@function-ability.com.

Sincerely

Nick Gurevich, CEO
FunctionAbility Rehabilitation Services