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REPORT TO INSURANCE BUREAU OF CANADA

NEWFOUNDLAND & LABRADOR AUTO INSURANCE SYSTEM: BENEFITS AND CHALLENGES ASSOCIATED WITH:

- **DEFINING INJURIES SUBJECT TO NON-PECUNIARY DAMAGES CAP;**
- **ACCESS TO EVIDENCE-BASED TREATMENT PROTOCOLS; AND**
- **IMPACT OF LITIGATION ON RECOVERY FROM TRAFFIC INJURIES**

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INTRODUCTION

I have been asked by Insurance Bureau of Canada (IBC) to offer commentary, from a health and rehabilitation perspective, on its recommendations to the Newfoundland and Labrador (NL) Board of Commissioners of Public Utilities (PUB) for auto insurance reforms. IBC has recommended introduction of a non-pecuniary damages cap and evidence-based treatment protocols for NL residents who sustain minor injuries[1]. This paper will consider, from a health and rehabilitation perspective:

1. Risks and benefits of defining minor injuries for the purpose of legislation;
2. Effects of litigation on the resolution of injuries should the definition of minor injury be too broad or too narrow; and
3. Opportunity for evidence-based treatment protocols to deliver better care for more injured persons.

While not requested by IBC, I have also taken the liberty of commenting on some implementation issues that may be of interest if the government pursues the reforms suggested.

I am a registered physiotherapist in good standing since 1979 and I have a master's degree in Rehabilitation Science. In my professional capacity, I have personally treated over a thousand people injured in traffic collisions and from other causes. I have also been engaged in the introduction of minor injury definitions and/or evidence-based protocols in Alberta, Nova Scotia, New Brunswick and Ontario. This has allowed me to work closely with multiple stakeholders including the general public, governments, health professional associations, individual medical rehabilitation providers and insurers to address the definition of minor injury, issues associated with evidence-based treatment protocols and implementation of both. It is my opinion that, if well executed, the reforms proposed by IBC can give more injured persons better and more effective care. It is axiomatic that when patients receive good care, without a lot of bureaucracy, they are more likely to recover quicker and less likely to perceive his/her insurer as an adversary. This can lead to better health outcomes, fewer disputes and less litigation, all of which should contribute to lower overall costs.

[1] Throughout this paper I have used the terminology "minor injury" to be consistent with the commonly used term for injuries, such as sprains and strains, for which the natural history anticipates recovery and restoration of full functional abilities within a limited period of time. As discussed later in this paper, calling these injuries "minor" can connote disregard for the experience of people who have incurred them. For this reason, I recommend replacing the term with other, more neutral, wording.

DEFINING INJURIES SUBJECT TO A NON-PECUNIARY DAMAGES CAP

IBC has recommended that the NL PUB consider categorizing and defining injuries that would be subject to a non-pecuniary damages cap. They propose a definition that would capture

> *Sprains, strains and whiplash injuries, including any clinically associated sequelae, whether physical or psychological in nature, that does not result in a serious impairment.*

It is understood by the health care community that some patients who initially suffer these kinds of injury may go on to experience longer term symptoms in the form of chronic pain conditions or prolonged psychological distress. While these cases are the exception, the definition must acknowledge the possibility and include a mechanism to enable compensation for injury impacts that are in excess of what is expected for minor injury. This possibility is provided for in IBC's proposal through the exception stipulated for minor injuries that result in serious impairment. The exception would apply to individuals who, in spite of having received appropriate, evidence-based treatment, go on to develop ongoing impairment that restricts their ability to function in the common tasks of daily life. Developing a meaningful definition of serious impairment will be an important component of the definition of minor injury.

Define Minor Injuries Realistically

A comprehensive 2015 study by Canadian and international scientists and health practitioners identified a class of traffic injuries, called 'Type 1' injuries, that have a positive natural history and are likely to recover within days or a few months. These are the kinds of injuries that one might want to include in a 'minor' injury cap because, by definition, they do not lead to prolonged pain and suffering in the majority of cases. The report, called *Enabling Recovery from Common Traffic Injuries: A Focus on the Injured Person*[2], describes Type I injuries as follows:

> *Type I injuries are those traffic injuries which have been shown in epidemiological studies to have a favourable natural history (recovery*

[2] Cote P, Shearer H, Ameis A, Carroll L, Mior M, Nordin M and the OPTIMa Collaboration. Enabling recovery from common traffic injuries: A focus on the injured person. UOIT-CMCC Centre for the Study of Disability Prevention and Rehabilitation. January 31 2015. Pg. 68.

> *times ranging from days to a few months). These injuries include musculoskeletal injuries (such as Neck Pain and Associated Disorders (NAD) Grades I-III, Grades I and II sprains and strains of the spine and limbs); traumatic radiculopathies; mild traumatic brain injuries; and post-traumatic psychological symptoms such as anxiety and stress.*
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> *Most often, Type I injuries improve within days to a few months of the collision, leaving no permanent serious impairment. Typically, the impact of even the most effective treatment for Type I injuries is modest, and usually limited to a reduction in symptom intensity.*

It is tempting to define minor injury by simply listing the diagnoses described above. But the definitional challenge is not quite so simple, as the study also contains the following observations about these injuries.

> *Injuries resulting from traffic collisions often present as clusters of physical, mental and psychological impairments. Although the primary symptom of NAD is neck pain, it also includes physical and psychological symptoms, such as back pain, headaches, arm pain, temporomandibular disorders and depressive symptomology.*

In other words, injuries resulting from traffic collisions do not present homogeneously in all patients and are sometimes not isolated to the physical realm. The medical literature confirms that injuries may present as clusters of physical, psychological and pain effects. Patients who share a single diagnosis may present with various symptoms and symptom severity. But, regardless of how an individual presents after a minor injury, the evidence also shows that most recover within a relatively short time period.

For this reason, I am in favour of IBC's recommendation that the definition not be limited to a list of physical injuries, but that it also captures the common "side-effects" or sequelae of minor injuries, which may include mental and psychological symptoms.

Define the Exceptions: serious impairment

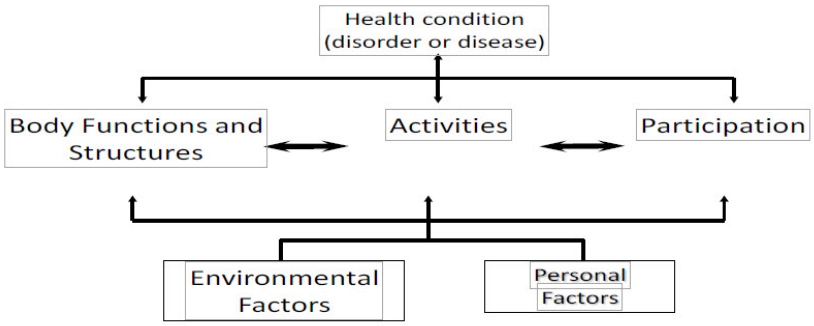
Research has shown that a small percentage of those who suffer minor/Type 1 injuries may go on to develop prolonged disability or chronic conditions such as chronic pain syndromes or debilitating psychological impairments. These individuals should not be penalized by a minor injury cap when the effects of their injury lead to serious impairment in the person's ability to function in their daily life.

But *serious impairment* cannot be defined by diagnosis. I have treated patients with whiplash initiated chronic pain syndrome who are able to work and participate in family life. I have also treated persons with the same diagnosis, but who are not able to function at a level to permit work or participation in family life. It is for the purpose of distinguishing between these different impacts that the World Health Organization (WHO) has adopted the International Classification of Functioning, Disability and Health (ICF)[3], which is a framework for describing and organising information on functioning and disability. The aims of the ICF include but are not limited to:

- Providing a scientific basis for understanding and studying health and health-related states, outcomes, determinants, and changes in health status and functioning;
- Establishing a common language for describing health and health-related states in order to improve communication between different users, such as health care workers, researchers, policy-makers and the public, including people with disabilities.

The ICF conceptualises a person's level of functioning as a dynamic interaction between her or his health conditions, environmental factors, and personal factors. It is a biopsychosocial model of disability, based on an integration of the social and medical models of disability.

Figure 1: WHO ICF



The identification of serious impairment must therefore be based not solely on the health condition, but also on an assessment of various factors that influence how

[3] https://www.cdc.gov/nchs/data/icd/icfoverview_finalforwho10sept.pdf

individual *functions* in his/her environment. It is the combination of all these factors that determine the true effect of an injury on an individual's participation in the ordinary activities and enjoyment of life.

Further to these observations, I would recommend against defining serious impairment based on a chronological timeline. This is because while patients may experience various symptoms long after an injury is incurred, many are able to participate fully in his/her life while others may not. As the definition of serious impairment in use in other Canadian jurisdictions have aligned with the ICF model of functioning, I recommend looking to these examples as models for adoption in NL.

ACCESS TO EVIDENCE-BASED TREATMENT THROUGH TREATMENT PROTOCOLS

It is my experience that medical and rehabilitation costs decrease when injured persons know what to expect and have access to evidence-based treatment. This is important when considering data[4] on no-fault Accident Benefits costs, which show average medical/rehabilitation claim costs in NL have increased from $3,607 in 2001 to $7,491 in 2017, an increase of more than 108% as compared to a 32% increase in cost of living over the same time period. These data suggest that in spite of advances in rehabilitation research and techniques to help injured people recover from traffic injuries, it is costing more to provide rehabilitation care to injury victims in NL. Moreover, in spite of more money being spent on treatment, injured people are not getting better and are therefore being deemed eligible for compensation for extended pain and suffering.

Regardless of how a person is injured, or who was at fault, treatment should be consistent and based in the scientific evidence of effectiveness so the public can have confidence that treatment is likely to promote good health outcomes. To deprive quality health care from persons who were in some way responsible for a collision is unethical and will result in higher costs to his/her family, insurers, the health care system and society at large. For this reason, I am a supporter of robust programs that are designed to protect the injured person's access to good quality treatment whether or not s//he was at fault. Maximal recovery is a shared goal of injured persons, health professionals and insurers. Having said that, I am often told by my colleagues that they encounter some insurance adjusters who appear to try to save money by denying claims for

[4] IBC with GISA data. 2018

effective treatment. I acknowledge that there may be a few misinformed adjusters who may not understand that costs decrease as health outcomes improve. But the fact is that costs to the insurance industry are reduced when individuals recover as fully as possible and, in my experience, the P & C insurance industry in Canada understands this.

While some patients with minor injuries do recover with little or no treatment, injured persons need to be given the opportunity to seek treatment that will promote recovery. Treatment protocols set out a framework of care that is based on research. They should include recommendations for treatment known to be effective as well as guidance to avoid treatments that have been shown to be ineffective. For example, research has shown that a soft collar to treat neck associated disorders (whiplash) is not recommended and indeed, can prolong disability. While insurers should not be able to deny access to treatment recommended in a protocol, they should not be required to pay for goods/services that are known to be ineffective.

Access to evidence-based treatment of minor injuries should also be easy, without a lot of paperwork, delays or bureaucracy. This means that treatment in the protocols should be pre-authorized so that claimants, once diagnosed, can begin appropriate treatment and receive guidance as soon as possible.

Experience in other jurisdictions teaches that treatment protocols also need to include a costing model that discourages over-treatment or inappropriate treatment. For example, the fee-for-service model rewards treatment visits and does so whether health outcomes are good or bad. I would also strongly encourage the inclusion of mandatory, standard health outcome measurement as part of the treatment protocols. This would increase accountability on the part of the treatment provider and help the injured person and insurer get a better sense of the extent to which treatment is helping. It would also permit a mechanism by which stakeholders could evaluate the effectiveness of the system in achieving recovery for injured persons.

Treatment protocols should not be overly prescriptive and should allow for health practitioners who initiate treatment to exercise clinical judgement in designing a treatment plan for an individual patient. One advantage of treatment protocols is that its presence allows the public and insurers to recognize when treatment is atypical and empowers them to engage the health professional in discussion about the treatment plan.

My personal experience in medical rehabilitation practice has confirmed to me that injured claimants who can access the right resources at the right time to recover

maximally have better health outcomes and quality of life. In 2008 I was an author of a peer reviewed paper that examined the effects of introducing a minor injury cap as well as treatment protocols for persons with minor injuries in Alberta in 2004[5]. The study demonstrated that introduction of treatment protocols led to:

- More injured persons accessing treatment in the first 12 wks post-injury
- Higher costs *per treatment* at 12 and 26 wks post-injury
- Higher costs *per claim* at 12 wks post-injury;
- Lower average cost *per claim* at 26 wks post-injury;
- Fewer episodes of disputes requiring an independent medical examination
- Higher rate of claim closure, which is accepted in the medical literature as a reasonable proxy for recovery [6].

In short, as compared to the pre-reform period, more injured claimants were getting treatment early after injury, and insurers were paying more per treatment and in overall claim costs in the first 12 wks after injury. But, due to improved recovery rates in the first 12 wks post-injury, average claim costs were reduced by 26 wks post-injury, and there were also more closed claims and a lower incidence of disputes. Clearly this was a win-win. Insurers paid more for treatment but paid less overall for claims.

Another reason why treatment protocols can reduce medical and rehabilitation costs is by limiting over-treatment or the provision of unnecessary treatment. There is often a perception on the part of the general public that more treatment must be better and it is not unusual for patients with Type 1 injuries to receive 30 to 40 treatment visits. But when it comes to minor/Type 1 injuries, the medical evidence suggests otherwise. The report on Common Traffic Injuries[2] states:

Most often, Type I injuries improve within days to a few months of the collision, leaving no permanent, serious impairment. Typically, the impact of even the most effective treatment for Type I injuries is modest, and usually limited to a reduction in symptom

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[5] Sulzenko-Laurie B, Riis V, Grubisic E. A Survey of Injury Claims Data After Introduction of Injury Care Protocols in Alberta, Canada. Journal of Occupational and Environmental Medicine. Vol S2, No 4, Apr 2010.

[6] Carroll LJ, Holm LW, Hogg-Johnson S, Cote P, Cassidy JD, Haldeman S, Nordin M, Hurwitz EL, Carragee EJ, van der Velde G, Peloso PM, Guzman J. Course and Prognostic Factors for Neck Pain in Whiplash Associated Disorders (WAD). Spine, Vol 33, No 45, 2008. pp S83-92.

intensity. The evidence concerning the effectiveness of current interventions for Type I injuries can be summarized as follows:

> *(1) most interventions produce, at best, short-term benefits in the form of symptom relief and/or increased function;*
>
> *(2) for such interventions, there is no evidence that effectiveness can be increased through higher dose intensity, more frequent attendance or prolongation of course of treatment;*
>
> *(3) there is* ***no evidence supporting a 'piling on' of complex combinations of clinicians, therapists, or therapies;*** *and*
>
> *(4) many commonly used interventions provide no more benefit than sham or placebo.*

In other words, while making more treatment or more kinds of treatment available might seem like a good idea, there is no scientific evidence to support this and, in fact, there is evidence that engaging multiple treatment providers will not result in improved health outcomes. A treatment protocol can discourage payment for unnecessary treatments that do little to contribute to good health outcomes.

Extension of Treatment Beyond the Protocols

IBC has recommended making Accident Benefits (Section B) mandatory and increasing benefit levels to the Maritime levels of $50,000 for med/rehab. In my view, this is a sound recommendation. It will be valuable to those persons with minor/Type 1 injuries who may not recover within the pre-authorized treatment protocols and require further treatment. More significantly this change will be of great benefit to those with serious injuries requiring extensive medical rehabilitation.

IMPACT OF LITIGATION ON RECOVERY FROM INJURY

No-fault medical and rehabilitation benefits provide equitable access to rehabilitation for everyone injured in traffic collisions. This is true regardless of the severity of injury or fault. And while tort litigation has a long history in determining compensation for pecuniary and non-pecuniary losses, there are rehabilitation and health consequences associated with litigation. Simply stated, litigation and the prospect for large financial awards tend to reward poor health outcomes more generously than good ones.

In NL, the vast majority of injured persons have access to additional benefits, through the Accident Benefits portion of their policy and/or through Bodily Injury litigation. NL's

current rules appear to allow fairly easy access to litigation, which presents the potential for large financial payouts. For this reason, many traffic injury victims pursue this route – regardless of the severity of the initial injury. Yet, if the purpose of auto insurance coverage is to facilitate recovery of any financial loss and, most importantly, enable injured people to recover and return to their pre-accident lives, it is my experience that the litigation process can often undermine achievement of this latter goal. This has been documented in the medical literature [6,7].

For example, an Australian inquiry found that the practise of linking benefits to a negligence suit delayed rehabilitation-related treatment, in part because of insurer unwillingness to accept early liability, and that linking the size of the award to the severity of injury also provided disincentives to effective recovery[7]. While this is not necessarily true in all cases, I can attest to it being true in patients with whom I have worked, some of whom received instruction from counsel not to go back to work or normal activities until they felt 100% better. This instruction is contrary to basic rehabilitation principles. As any rehabilitation specialist knows, one does not arrive at 100% recovery without starting to do the activities which will constitute recovery.

Another common and often costly problem in adversarial systems is when two medico-legal reports come to conflicting opinions. Thus, as the Australian Attorney General in 1996 said at a public seminar on their motor accidents system: “One important basis upon which any compensation is determined is, of course, the medical report. Trial judges have remarked to the Motor Accidents Authority that in some cases the differences between medico-legal reports tendered by the parties are so great as to cast doubt as to whether they are related to the same person.”[8] In other words, the tort system is being cited for distorting the focus of medicine and medical assessments away from recovery and restoration of function for the injured person and towards the achievement of purely financial rewards.

I support the right of innocent victims of negligence to compensation for pecuniary and non-pecuniary losses, but I can’t ignore the fact that the litigation process may establish goals for some injured persons that conflict with the intention of first party benefits to improve the injured claimant’s health, reduce disability and encourage a return to pre-

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[7] O’Donnell C. Motor accident and workers’ compensation insurance design for high-quality health outcomes and cost containment. Disability and Rehabilitation. 2000; v o l . 22, no . 1/ 2, 88-96

[8] Standing Committee on Law and Justice. *Proceedings of the Public Seminar on the Motor Accidents Scheme*. Sydney: Government Printer, 1996; 57, 91- 96; pg 12.

injury functioning. As a health professional, I see this as particularly problematic in the case of the kinds of injuries where the normal expectation is for recovery to happen naturally and over a limited period of time.

IMPLEMENTATION

While I have not been asked to comment on implementation, I respectfully ask the NL PUB to indulge me, because in my view, there is room to consider strategies that could secure long term success of the reforms discussed in this paper. Should the NL PUB consider implementing the reforms recommended, three implementation issues include:

- Terminology
- Consumer education
- Stakeholder education

Terminology

Definitions used in legislation and regulation are not intended to serve a medical purpose, but my experience is that insurers and health care professionals start to use the legal terminology with patients, even though there is no medical context for it.

In this report, I have used the terms *minor* and *Type 1* injury synonymously. While minor is in use across various jurisdictions in Canada to describe Type 1 injuries, there is evidence it creates distress because it implies disregard for the actual experience of those who incur such injuries. The Common Traffic Injuries report examined perspectives of injured persons in Ontario who sustained 'minor' injuries. Those individuals reported that the word 'minor' trivialized the extent and impact of the injuries they experienced[9]. This in turn, can create a perception of injustice on the part of injured claimants who are told that their injuries are *minor* and this is taken to imply that their feelings of pain and distress are not legitimate. Perceived injustice is a factor that has been associated with poorer health outcomes and prolonged disability[10]. So, while I used the term minor injury in this paper for the reason of continuity, I would recommend considering ways to avoid the term in the final definition. Replacing 'minor' with 'Type 1'

[9] Cote P, Shearer H, Ameis A, Carroll L, Mior M, Nordin M and the OPTIMa Collaboration. Enabling recovery from common traffic injuries: A focus on the injured person. UOIT-CMCC Centre for the Study of Disability Prevention and Rehabilitation. January 31 2015. Pg. 68.

[10] Sullivan, MJL, Thibault P, Simmonds J, Milioto M, Cantin A, Velly AM. Pain, perceived injustice and the persistence of post-traumatic symptoms during the course of rehabilitation for whiplash injuries. Pain. 145 (2009) 325-331.

injuries may be a simple fix and would place NL in the forefront of evidence-based decision-making.

Consumer Education

Auto insurance systems tend to be complex and difficult to navigate. Most people won't be in traffic collisions and have no need to know the difference between first-party "no-fault" and third-party "fault-based" benefits. But once they engage in the injury claims process, the challenges of navigating the claims and medical rehabilitation systems become apparent even to the most sophisticated consumer. For this reason, I have long advocated that governments and health professional associations engage in more and ongoing consumer education about injuries caused in traffic collisions and how to navigate the system effectively. If reforms are considered, the implementation plan should give thought to development of public information that can be made available to help injured persons navigate the complex insurance and health systems. These materials should be reviewed and updated and disseminated on a regular basis.

Stakeholder Education

Health providers are good at what they do and insurers are good at what they do. I have spent much of my career bridging these two stakeholder groups because they don't always have insight into the challenges of each other's role in the system. Further, as evidence evolves, treatment protocols need to incorporate the new evidence so that they continue to be current. When Alberta implemented reforms including a minor injury cap and diagnostic and treatment protocols, there was formal collaboration between the involved health professional associations (physicians, physiotherapists, chiropractors), insurers and government. A Health Practitioner's Guide to the Diagnostic and Treatment Protocols was developed by a medical consultant and this was made available to health professionals and insurers. In addition, regular stakeholder meetings were held to discuss and (in most cases) resolve early issues around interpretation and billing. The result was a relatively smooth transition to the new system and a sense of collegiality and collaboration between health professionals and insurers. This in turn reduced the stress of uncertainty which occurs when health providers and insurers are not operating in a synchronous fashion. As I have advocated in other jurisdictions, periodic and ongoing review by stakeholders of how the system is working (or not working) and collaboration around solutions should be built in to the long-term monitoring of reforms. This suggestion, if adopted, would also set NL apart from other regions in terms of how it implements the reforms over the long term.

SUMMARY

The NL PUB is faced with the task of bringing together the needs of injured persons for effective health care and appropriate compensation and the need of drivers in NL for affordable and available auto insurance.

Having worked with the public, governments, insurers and health providers in a variety of jurisdictions that have implemented a minor injury cap and medical/rehabilitation treatment protocols, I support the recommendations made by IBC. IBC's proposal is aimed at limiting the pain and suffering amounts paid for victims with injuries that do not lead to prolonged disability or loss of function, and thereby reducing the cost of auto insurance for everyone. In other words, compensation for pain and suffering would continue, but at a level that is commensurate with the impact of the injury on the injured person's ability to function. For those whose minor injury goes on to evolve to a serious impairment with disability, the proposed definition preserves the right to seek pain and suffering compensation in excess of the cap. Evidence-based diagnostic and treatment protocols have been shown to improve health outcomes and lower overall claim costs. It is my experience that, if implemented well, reforms as recommended can improve the working relationship between insurers and health professionals in NL which in turn will improve the experience and health outcomes of injured persons in need of treatment.

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