Ontario Rehab Alliance

ORA Submission Re Proposed Amendments to Insurance Act Regulation 34/10 (Statutory Accident Benefits Schedule - Effective September 1, 2010)

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2015

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About the Ontario Rehab Alliance

Founded in 2009, the Ontario Rehab Alliance (ORA) is a non-profit association representing 135 healthcare organizations with over 4500 healthcare professionals. It is these professionals who are the primary providers of healthcare and rehabilitation services to the 65,000 Ontarians who are injured each year in motor vehicle accidents (MVA). Our member companies operate in the auto insurance sector as well as a variety of non-institutional sectors.

We are the only association focussed solely on the interests and issues of healthcare providers in the auto sector. We advocate on behalf of our members to influence government policy and public opinion on behalf of our members and the accident victims they support.

Our association is an active and constructive participant on multiple forums including *FSCO's Service Providers Licensing Forum*, the *HCAI Antifraud Group* and the *HCAI Forms Committee*.

Introduction

The ORA has long promoted and supported the implementation of service provider licensing, in place since December 1, 2014 and multiple other strategies intended to reduce fraud and improve the auto insurance system. Healthcare providers in this sector must now have a special license in addition to their professional licenses in order to treat those injured in accidents. We supported this measure, despite the significant cost to our members, because we hoped that such anti-fraud measures would end the cuts to accident benefits.

Nevertheless, **accident benefits for legitimate claimants have continued to experience "death by a thousand cuts" and have become a way for insurers to make money without having to properly manage their business, instead of what was intended – protecting injured drivers**. The changes now proposed, without any prior consultation with our sector or consumers, will negatively and dramatically impact legitimate and seriously injured claimants.

Without regulatory language to review, this submission and those of all other stakeholders, is constrained by a lack of information as to the specifics of the proposals, the mechanisms that will be revised or implemented to support them, and therefore the actual impact of the changes. Therefore, this submission touches largely on policy directions. However, because of the impact of the proposed amendments, we are also reiterating the impact we feel these proposals will have. Some of this commentary overlaps ORA submissions previously provided:

- *Submission to the Three Year Review of Auto Insurance by FSCO, March 31, 2014*
- *Response to Stakeholder Round Table on Catastrophic Impairments Summary of Proceedings, July 2013.*
- *Response to the Final Report of the Catastrophic Impairment Expert Panel to the Superintendent (April 8, 2011)*
- *Response to the Superintendent's Report on Catastrophic Designation* to the *Select Committee on Auto Insurance July in 2012*.

Further, we have presented on these issues multiple times in the past few years to the:

- Standing Committee on Finance and Economic Affairs
- Minister of Finance's Pre-Budget Consultations

Recommendation for Technical Consultation

It is vital that the Ministry undertake a technical consultation on the draft regulations prior to submitting the amending regulations for approval and include in that consultation the ORA and other stakeholders who can best understand and contribute to the government's understanding of the outcomes and impact.

We hear from insurers and government that Ontario has the "richest" coverage in Canada. This is far from the truth. A minor injury cap only exists in Ontario and reduces coverage to below what's available in every other Canadian jurisdiction. The government boasts that no other province has a catastrophic designation, yet there are some provinces that do not have an upper limit on medical benefits. *On balance, Ontario is now home to the lowest healthcare coverage in Canada even without these further proposed reductions.*

In Ontario, auto insurance is the last payer. That is, auto insurers only pay if public healthcare services and private extended benefits are either not available or exhausted. It is a fact that in Ontario most rehabilitation services are not covered by our OHIP system while our publicly funded homecare, delivered by the CCACs, is completely overburdened and provides negligible services other than to those with end of life or palliative care needs. Many private extended health benefit payers now exclude auto accidents. As a result, there is pressure on the auto insurance system to fund costs. The purpose of accident benefits is to bridge the gap between healthcare that is urgently needed in the immediate aftermath of an injury and settlement of a tort case. **Given that few rehabilitation services are available through our public system and tort may take years to settle, the currently proposed reductions are defeating the very basic premise of accident benefits.**

It is our view that the government needs to take a balanced approach to premium reductions. Since the introduction of no-fault insurance, each attempt to reduce premiums came at the expense of the victims while continuously guaranteeing insurers a rate of return. It is time to have insurers participate in the effort to reduce premiums and reduce their guaranteed Return on Equity to the 6% to 7% range which is in line with US based P&C insurers (as per an annual publication of US Treasury Department).

Proposed Amendment: Change the standard benefit level for medical and rehabilitation benefits to $65,000 (from $50,000) and include attendant care services under this benefit limit.

An option will be provided for consumers to increase this coverage to up to $1 million.

Comment & Recommendations

The combining of medical and rehabilitation benefits with attendant care services under the proposed combined limit of $65,000 is a $21,000, or 25%, reduction of the current $50,000 med/rehab and $36,000 attendant care benefit for those that are seriously injured. **The proposed reduced benefit is drastically inadequate**.

We support including attendant care services with medical and rehabilitation benefits to provide for greater flexibility, assuming current benefit levels are maintained.

Attendant Care Benefit

Prior to the 2010 reform, the Attendant Care benefit available to those who were non-catastrophically injured stood at $72,000 with a monthly maximum of $3,000. This means that the benefit was sufficient to last two years which provided a seriously injured person with the opportunity to be evaluated for catastrophic impairment status. With the $36,000 now available to the non-catastrophically injured, attendant care funding runs out within the first year. This leaves many in unhealthy, and more importantly, unsafe situations that result in financial, physical and emotional stress on families who have to leave work to provide care, and who have no caregiver relief. The impact of the 2010 reforms when the benefit was reduced from $72,000 to $36,000 was to reduce utilization by 90% from $72,000 to $7,200 on a weighted average basis (representing 99% of all victims).

If the proposed further reduction of $21,000 is taken from the Attendant Care benefit, that fund will be reduced from $36,000 to $15,000. When applying market rates of $25/hr for attendant care services, the benefit translates to only 25 days of care. Individuals with serious injuries who may not be able to move, transfer, dress, shower, eat, etc. without help, will go without care after that time. Thus, those with serious injuries, who typically need a range of therapy supports and assessments will be faced with an untenable choice between treatment and attendant care. That is not a choice they should be forced to make.

There is no rationale for additional cuts at this time when the current attendant care benefit is as noted drastically insufficient.

Attendant care benefits should not be further reduced through the proposed combination with med/rehab benefits. Rather, they should be increased to the pre-2010 level, to ensure the safety and wellbeing of those with the most severe injuries, including the serious non-catastrophic and those eventually deemed catastrophic.

Medical & Rehabilitation Benefit

Prior to the 2010 reform, the Med/Rehab benefit available to those who were not catastrophically injured was $100,000 excluding assessment costs. This meant that the benefit was sufficient to last two years until a seriously injured person could be evaluated for catastrophic impairment designation. With only $50,000 now available (and this now includes assessment costs), individuals with serious injuries (including those who will eventually be deemed catastrophic) are running out of funds well before they have a chance of recovery, sometimes in as little as three months.

In order to inform and support our submission to *FSCO's Three Year Review of Auto Insurance*, the Ontario Rehab Alliance surveyed providers working in the MVA sector in March 2014. (*Survey details were provided in that submission*).

Survey data showed that of those who get access to the full $50,000, only 50% are able to resume *half* of their pre-injury roles before funding runs out. This is down from 85% prior to the September 2010 changes. This shows a clear correlation between higher level of funding and rate of recovery/goal attainment.

For those inappropriately relegated to the MIG, the cut in benefit was 96% ($100,000 to $3,500). It can be assumed that these people have little to no chance of recovery.

It bears reiterating that the $50,000 cap provides less than $50,000 in treatment when assessment costs are factored in. Those with serious injuries now often find themselves without coverage long before they have achieved their rehabilitation goals. Those not immediately deemed as having catastrophic injuries now have to wait years to access additional funds, during which time their status usually deteriorates and it may be too late for efficient, effective rehab at settlement. Our members see this now with a large group of their serious non-catastrophic clients. It is worth noting that a lack of access to rehabilitation may potentially increase the possibility of catastrophic impairment designation if maximum recovery is not achieved.

What happens when the injured don't get the appropriate medical and rehabilitation support they thought they were insured for?

- They go without. Our publicly-funded health care system no longer provides much rehabilitation after shortened hospital stays; home care provides even less.
- Most rehabilitation services required for the seriously injured have been delisted, and are therefore no longer available for those without access to insurance.

Slashing insurer responsibilities to provide support will lead to:

- More physician and emergency room visits by those who have no other access to the right kind of care
- More people unable to return to work and therefore increasing the burden on ODSP, Ontario Works and food banks
- Caregiver burnout, family breakdown, addictions and incarcerations

The bottom line is that the proposed cuts will have devastating results for those with serious injuries, forcing them to choose between much needed assistance to get through the day and much needed assistance to improve their independence so that they will rely less on assistance in the future. This will only be heightened with the proposed narrowing of the catastrophic definition which will lead to increased severity of injury among this non-catastrophic population.

Medical and rehabilitation benefits for non-catastrophic serious injuries should not be further reduced through the proposed combination with attendant care, but rather increased to the pre-2010 level.

Proposed Amendment: Include attendant care services with the $1 million medical and rehabilitation benefit for catastrophic impairments, and provide the option for additional coverage of $1 million, for $2 million in total coverage.

Comment & Recommendations

This proposal will effectively reduce benefits by 50% from the $1 million medical and rehabilitation benefit and the $1 million attendant care benefit currently available for those with catastrophic impairments.

This will be disastrous for the injured, their families and society. With only $1 million combined available, those with catastrophic injuries will not receive the med/rehab and attendant care they need to maximize their levels of function and regain some semblance of their pre-accident lives.

We will undoubtedly see fellow Ontarians whose horrific crashes result in quadriplegia, severe brain injuries and amputations live the rest of their lives with little to no dignity. The impact of choosing between help to complete daily activities and rehabilitation to reduce the need for help in the future is magnified tenfold in this population. The future of these individuals' children, wives, husbands or parents will be forever changed as they have to rededicate their lives to becoming full time caregivers in light of deep cuts to the benefits. **We urge decision makers to spend a day with a catastrophically injured individual in order to understand the impact of the proposed cuts.**

We support including attendant care services with medical and rehabilitation benefits to provide for greater flexibility.

The current benefit levels of $1 million for medical and rehabilitation benefit and $1 million for attendant care should be retained.

Proposed Amendment: Require goods and services not explicitly listed in the statutory accident benefits schedule to be "essential" and agreed upon by the insurer.

Comment & Recommendations

The proposed new "essential" test for unlisted goods and services, which would presumably replace the current "reasonable and necessary" test is clearly intended to reduce claims by introducing a tougher test. The new test will create more disputes, and the cost on the system to resolve these disputes will eat up much of the savings. People will argue over the definition of "essential" as well as whether a particular good or service falls under these subsections. This is because what is "essential" to one claimant in a specific situation may not be "essential" for another. This will

merely add yet another focal point for delayed and disputed treatment plans to a system already clogged with disputes and delays. Adding to the complexity of the SABS benefits no one but lawyers. Certainly not consumers.

The "essential" test should not be introduced.

Interim Catastrophic Designation & Benefit

We support the establishment of an Interim Designation of Catastrophic Impairment. Currently, many of those who are very seriously injured find themselves without accident benefits as they await determination of catastrophic impairment. This has been the case for many years and has become more critical since medical and rehabilitation benefits were reduced to $50,000 in 2010. As benefit levels diminish, the need for an Interim Designation and benefit becomes more necessary.

Fair and reasonable access to interim catastrophic benefits should be introduced.

It appears, from comments made by Dr. Shafiq Qaadri, a sitting Liberal MPP at the recent Standing Committee presentations on Bill 91 on May 20, 2015, that the government is intending to include an interim benefit in the SABS as recommended by the Superintendent in 2011. However, there is no reference to an interim benefit in the Regulatory Registry posting. If the government has always intended to include the interim benefit in the regulation, the inadequacy of their posting is underscored. Both the government and stakeholders would be better served if more detail had been provided.

Updating the Definition of Catastrophic Impairment (CAT) to reflect the most up to date medical information and knowledge.

Amendments will be proposed based on the *Superintendent's Report on the Definition of Catastrophic Impairment* in the Statutory Accident Benefits Schedule, subject to modifications.

Prior Recommendations

We have actively contributed to this discussion over the past several years. *Response to the Final Report of the Catastrophic Impairment Expert Panel to the Superintendent (April 8, 2011)*, submitted in May 2011, presents a comprehensive articulation of our position. We subsequently submitted a response to the *Superintendent's Report on Catastrophic Designation* to the *Select Committee on Auto Insurance July in 2012*.

By way of background, in 2011 the ORA struck its own expert panel to review the *FSCO Expert Panel's* proposed changes to the catastrophic definition. The FSCO panel was comprised of only eight individuals, most of whom were researchers/academics with little to no experience working with auto insurance claimants, and half of whom were consultants to the Insurance Bureau of Canada (IBC), and therefore could be considered biased towards the need of insurers over the insured. In contrast, our panel was comprised of 25 clinicians/experts, including leaders in the field of physical medicine and rehabilitation, neurosurgery, neuropsychiatry and neuropsychology, experienced clinicians who treat accident victims every day, as well as a range of other stakeholder groups, including the Ontario Paraplegic Association, the Ontario Brain Injury Association and the Toronto ABI Network. **To eliminate bias our panel was mostly comprised of public sector clinicians or non-for-profit victims' associations who had no vested interest in the outcome**.

In May 2011, we submitted a detailed 50-page response to the FSCO panel's 14 page report- based upon the evidence and our clinical experience. (*See Appendix A for the Executive Summary and Contributor List*). Our panel came to the conclusion that there were major flaws in the FSCO Panel's recommendations. We made specific recommendations to

address these flaws, including that existing assessment tools should not be replaced with new tools before the new tools were proven valid and reliable, and ensuring the cut-off points and criteria allowed for equal and fair access to all those requiring long term and intensive access to services and support. With only one exception, our recommendations were ignored by the Superintendent in his final report.

In summary, our panel found the changes to the catastrophic definition as proposed by the FSCO Panel and Superintendent:

- Discriminatory
    - Discriminated against those who live in rural areas (e.g. would not have access to Level 1 Trauma Center for imaging, a rehab facility or access to a neuropsychiatrist- all necessary under the proposed changes to potentially qualify as catastrophic)
    - Discriminated against those who have mental or pain impairments vs physical impairments (by not allowing the combination of these impairments reportedly because it could not be done, when in fact the AMA Guidelines provide a clear method of doing so)
    - Discriminated against children (the proposed definition did not apply to children with some serious disabilities, including psychiatric impairments).
- Not based on good science
    - Recommended replacing tests that have proven to be valid and reliable tests (e.g. GCS, AMA Guides/Chapter 14, Paralysis), with tests (and subtests of tests) that, as admitted by the panel, have not yet been proven valid or reliable in community settings (e.g. GOSE, KOSHI, SCIM subtest 12, GAF))
- Excluded many individuals who require intensive long term rehab and support
    - Our experts predicted that under the new definition the number of people deemed catastrophic will be cut in half, when in fact a new definition should be more inclusive as funds are running out in six to 12 months
- Increased complexity/legal disputes/backlogs
    - The proposed changes would make the system even more complex and adversarial, resulting in even more disputes, more money going to lawyers versus treatment, and more people suffering.

Round Table Consensus

The *May 2013 Stakeholder Round Table on Catastrophic Impairment* revealed a clear consensus by all stakeholders, excluding insurers, that there is little support for the FSCO panel's and the Superintendent's recommendations to change the criteria. There was no indication that there was a need for change; i.e. that too many people, or the wrong people, are accessing catastrophic benefits. In fact, the consensus was that given the cut in serious non- catastrophic benefits, if any changes were to be made, it should be to make the catastrophic definition more inclusive (that is, make it easier not harder to qualify), and ensure adequate coverage for those awaiting catastrophic determination.

However, there was agreement that the lack of standards and certification for catastrophic determination assessors has led to assessments that are unfair and/or biased.

Comment & Recommendations

Proposed changes to the definition of catastrophic impairment should not be introduced without further consultation. The government should strike a multi-stakeholder committee with the mandate to not only address the needs of the insurance industry, but also to ensure the seriously injured are adequately protected.

We recommend that such multi-stakeholder committee(s) look into the following:

- A comprehensive literature review, including Bayley et al, around outcome indicators.
- Clarity around the Interim Catastrophic Designation.
- Catastrophic designation assessor qualifications and process.
- How to best ensure children with Traumatic Brain Injury with delayed onset of deficits have access to support.
- How to best combine physical and mental/behavioural ratings.

We recommend combining physical and mental/behavioural ratings by analogy using Guides 4 Chapter 4, Table 3 or using the California method to convert GAF scores to WPI.

This process should include the application of the proposed new definitions to actual cases.

Any revised catastrophic definition should be more inclusive, not less.

Any new tools introduced should only replace the existing tools once they have been proven to be better predictors of outcome and needs, as well as valid and reliable.

It is critical to realize that the insurance industry's rationale for the cuts in 2010 was that it was assumed that there was widespread abuse and fraud across all injury groups. In fact, we now know that the fraud and abuse that did exist occurred primarily in the minor injury group, and this has been addressed with the introduction of the minor injury cap. Importantly, FSCO is reporting only positive experiences as it audits providers under the new licencing system.

Sadly, in 2010, the serious non-catastrophic claimants were made a casualty of the "war on fraud"- having their benefits cut when they should have been increased. Now, instead of addressing that mistake, this government is planning additional cuts to the non-catastrophic benefits, cutting catastrophic benefits in half, and making it much more difficult to qualify as catastrophic - with the only apparent rationale being that insurers' profits need to be bolstered. These changes will destroy the system, making it impossible for those with serious injuries (which could be us or our loved ones) to have any chance of once again being a productive member of society and enjoying some quality of life.

As referenced previously in the Introduction, our ability to comment is constrained by lack of detail in the proposal. As for the other proposed catastrophic definition changes that follow, below, the government should be made aware that some of these categories of impairment (e.g., paraplegia and quadriplegia) involve very few cases. Switching to more complicated and involved criteria and tests may make sense from a scientific perspective but adds tremendous complexity and administrative costs to the system. If there are any savings, which in some cases is questionable, they will be eaten up by other costs. The new definition will create 10 years of disputes and litigation that will mostly benefit the legal profession.

Proposed Amendment: Traumatic Brain Injury: eliminate the Glasgow Coma Scale (GCS) and adopt the extended Glasgow Outcome Scale (GOS-E); adopt use of King's Outcome Scale for Childhood Head Injury (KOSHI).

For adults, eliminate the Glasgow Coma Scale (GCS) and adopt the extended Glasgow Outcome Scale (GOS-E) as the clinical assessment tool; For children under 18 adopt use of King's Outcome Scale for Childhood Head Injury (KOSHI) as the clinical assessment tool.

Comment & Recommendations

The recommendations from our expert panel submission and other stakeholder group feedback should be considered by the multi-stakeholder committee before any changes to the catastrophic definition are considered, specifically:

- The GCS of 9 or less continue to be deemed catastrophic, until such time at the GOS-E has been proven to be a valid and reliable outcome measurement tool.
- Both children and adults should be deemed definitive catastrophic upon positive imaging, which is done at any credible center, if those changes are found to be a result of the accident.
- Both children and adults should be deemed definitive catastrophic if they are accepted into an inpatient rehabilitation program; however, inpatient rehab should not be a requirement
- Adults with TBI at the V GOS-E level at 1 one month (versus 3) and the SD level at 3 months (versus 6) be deemed definitive catastrophic.
- Adults with TBI and the MD upper or lower (versus just lower) at 6 months (versus one year) be deemed Interim Catastrophic.

Proposed Amendment: For mental and behavioural impairments, revise the definition to include updated detailed criteria and new diagnostic tools.

Comment & Recommendations

We support retaining the use of the term “mental and behavioural” for impairments due to mental and behavioural disorders rather than using the term ‘psychiatric’, as per the government’s proposal.

We advise retaining the use of AMA Guides 4, chapter 14, for determination of marked or extreme impairment due to mental and behavioural disorders.

If the Global Assessment of Functioning (GAF) is adopted as a measure for impairments due to mental and behavioural disorders, establish the threshold at a GAF of 50.

- Establishing a threshold at a GAF of 40 as recommended by the Superintendent is discriminatory and inequitable. It requires a much higher threshold than for impairments due to physical disorders and unfairly disadvantages accident victims with impairments due to mental disorders.
- A GAF of 40 is the equivalent of quadriplegia and an individual whose impairments *preclude* useful functioning. Definitions for other physical impairments are more consistent with *impeding* but not *precluding* useful functioning, which is consistent with a GAF threshold of 50.

The indicia as described by the expert panel are discriminatory and must be revised or removed.

- These indicia as described by the expert panel are the equivalent to an individual whose impairments *preclude* useful functioning, e.g. quadriplegia. Definitions for other physical impairments are more consistent with *impeding* but not *precluding* useful functioning.
- If a list of indicia is to be included in the definition it must be consistent with a threshold of a GAF of 50 to avoid discrimination.
- Given the number of factors that influence utilization of and access to health care, confirm that a list of indicia is intended to be illustrative, but not required.

Do not include a limited list of specific mental and behavioural diagnoses that may be considered for catastrophic impairment determination.

The use of a limited list that includes only a subset of mental and behavioural disorders is unscientific and discriminatory. It is also unnecessary as any diagnosed disorder must be shown to be a result of a motor vehicle accident, and any mental and behavioural impairment must be due to that disorder.

Provide more equitable access for accident victims with impairments due to mental and behavioural disorders to assessors with appropriate expertise.

Include psychologists in the designated professions able to conduct catastrophic impairment examinations and complete applications

Proposed Amendment: Paraplegia or Quadriplegia: Revise the definition with updated detailed criteria and new diagnostic tools.

Comment:

All spinal cord injuries, which include paraplegia or tetraplegia (whether the spinal cord injury is classified as complete or incomplete), central cord syndrome, caudaequina syndrome, and/ or Brown Sequard Syndrome should be deemed to be catastrophic.

Item #12 from the SCIM-3 is not a valid predictor of extent of functional limitations experienced by an individual with spinal cord injury, nor of catastrophic impairment.

Proposed Amendment: Total and permanent loss of use of an arm or leg: Revise the definition with detailed criteria and new diagnostic tools dealing with impairment of ambulatory mobility.

Comment:

Severe Impairment of Ambulatory Mobility:

Amending the criteria to include people with mobility issues from amputation or from permanent alteration to one or both lower limbs is supported given the severe impact this has on an individual's ability to function independently.

However, scoring 0-3 on Item 12 from the SCIM-3 does not adequately capture this intended group nor does it seem to be consistent with including individuals who use bilateral mobility devices as recommended by the Panel.

Proposed Amendment: Allow for automatic CAT designation of children in certain cases.

Comment & Recommendations:

We support the use of a tool specifically designed for children in the case of paediatric Traumatic Brain Injury (TBI).

Catastrophic designation of children and access to benefits must take into account that children with TBI can experience delayed onset of deficits, and require long term follow-up, even many years post injury.

Proposed Amendment: Combination of impairments: For other physical impairments not listed retain current definition and adopt new diagnostic tool (6th Edition of AMA Guides to the Evaluation of Permanent Impairment) for quantifying mental and behavioural impairments for the purposes of combining.

Comment & Recommendations:

It is fair and equitable to combine all impairments. However, use of Guides 6, as proposed by the government, introduces inequity and discrimination. Rating by analogy within Guides 4 or using the California method are alternatives that are fairer and more equitable.

Optional Buy-Up

Comment & Recommendations

When it comes to buying auto insurance consumers do not know what they are buying and they are not getting what they think they paid for. Tragically, most don't find this out until they are injured. Most drivers assume that their medical and rehabilitation needs will be covered by the basic package most of us have, and the shortfall will be easily picked up by our publicly funded healthcare system. But they're wrong. The publicly funded system is severely underfunded and the current cap of up to $50,000 in med/rehab coverage for serious, non-catastrophic injuries which is, practically speaking, often 'converted' to the much lower spending cap $3,500 in the Minor Injury Guideline, is insufficient. This amount must cover not only physical injuries but also treatment for debilitating mental health conditions that can result from an accident. And, in many cases of minor injuries, claimants' treatment dollars often never exceed the initial $2,200, when provider applications demonstrating the need for the additional $1,300 are often denied. Our survey respondents reported that 26% of MIG clients who clearly required more care were unable to access more than $2,200 of MIG treatment dollars.

Since 1996, with the passage of Bill 59, the government has been cutting accident benefits. Each time benefits are cut the government uses the same rationale - explaining that consumers have the option to buy up. In reality, the tactic of supporting the purchase of optional benefits is insincere. Take up has historically been very low because the government does not promote the purchase of optional benefits and brokers and agents advise against purchasing them even though they consistently recommend purchase of additional liability coverage. According to FSCO, only 1.4% of consumers have purchased optional med/rehab benefits. Most consumers who purchase them are system "insiders" who understand the impact of not doing so.

When the last round of changes to the SABS was made in 2010, there was again much talk of improved consumer choice, with insured drivers having the option to 'buy up' so that they may – only if they need it and only if their insurance company agrees – access up to $100,000 or $1,000,000 in med/rehab benefits, access up to $72,000 in attendant care, and have access to caregiving and housekeeping benefits. Even when those few policy holders know enough to buy up, their benefit limits remain subject to the $3,500 Minor Injury Guideline, intended to capture upwards of 80% of accident victims. We believe that very few insured drivers have any understanding of this.

Past cuts to benefits have never stabilized premiums and they won't this time around. A substantial portion of the "savings" shifts into tort where transaction costs are even higher than in no-fault. In addition, the proposed changes will increase disputes in the system and the cost of resolving these disputes will further erode any savings. If this round of savings is about protecting consumers, then the ORA would like to see the government dedicate resources to properly educate consumers and ensure that brokers and agents are doing their job by helping consumers make informed choices.

A good start would be by retaining an appropriate level of coverage in the basic benefits package and requiring consumers to buy down.

If optional buy up of basic benefits is to be anything more than empty words, the Ministry of Finance must require that insurers and brokers fully inform consumers and advise them of the risks of underinsuring. In the interest of public safety, consideration must be given to punishing brokers who do not inform their clients of this option.

Summary of Recommendations

1) It is vital that the Ministry undertake a technical consultation on the draft regulations prior to submitting the amending regulations for approval and include in that consultation the ORA and other stakeholders who can best understand and contribute to the government's understanding of the outcomes and impact.

2) We support including attendant care services with medical and rehabilitation benefits for both serious, non-catastrophic and catastrophic injuries, assuming current benefit levels are maintained, to provide for greater flexibility.

3) Attendant care benefits should not be further reduced through the proposed combination with med/rehab benefits. Rather, they should be increased to the pre-2010 level, to ensure the safety and wellbeing of those with the most severe injuries, including the serious non-catastrophic and those eventually deemed catastrophic.

4) Medical and rehabilitation benefits for non-catastrophic serious injuries should not be further reduced through the proposed combination with attendant care, but rather increased to the pre-2010 level.

5) The current benefit levels of $1 million for medical and rehabilitation benefit and $1 million for attendant care should be retained.

6) The "essential" test should not be introduced.

7) Fair and reasonable access to interim catastrophic benefits should be introduced.

8) Proposed changes to the definition of catastrophic impairment should not be introduced without further consultation. The government should strike a multi-stakeholder committee with the mandate to not only address the needs of the insurance industry, but also to ensure the seriously injured are adequately protected.

9) We recommend combining physical and mental/behavioural ratings by analogy using Guides 4 Chapter 4, Table 3 or using the California method to convert GAF scores to WPI.

10) Any revised catastrophic definition should be more inclusive, not less.

11) Any new tools introduced should only replace the existing tools once they have been proven to be better predictors of outcome and needs, as well as valid and reliable.

12) We support retaining the use of the term "mental and behavioural" for impairments due to mental and behavioural disorders rather than using the term 'psychiatric', as per the government's proposal.

13) We advise retaining the use of AMA Guides 4, chapter 14, for determination of marked or extreme impairment due to mental and behavioural disorders.

14) Do not include a limited list of specific mental and behavioural diagnoses that may be considered for catastrophic impairment determination.

15) Provide more equitable access for accident victims with impairments due to mental and behavioural disorders to assessors with appropriate expertise.

16) Include psychologists in the designated professions able to conduct catastrophic impairment examinations and complete applications

17) All spinal cord injuries, which include paraplegia or tetraplegia (whether the spinal cord injury is classified as complete or incomplete), central cord syndrome, caudaequina syndrome, and/ or Brown Sequard Syndrome should be determined to be catastrophic.

18) We support amending the criteria to include people with mobility issues from amputation or from permanent alteration to one or both lower limbs given the severe impact this has on an individual's ability to function independently.

19) It is fair and equitable to combine all impairments. However, use of Guides 6, as proposed by the government, introduces inequity and discrimination. Rating by analogy within Guides 4 or using the California method are alternatives that are fairer and more equitable.

Appendix A: Contributors to ORA Response to the Final Report of the Catastrophic Impairment Expert Panel to the Superintendent (April 8, 2011), submitted in May 2011.

The following people contributed in whole or in part and/or supported whole or in part this document:

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Dr. Donna Ouchterlony, M.D., CCFP, Director of St. Michael's Head Injury Clinic (all)

Dr. Van Reekum, M.D., F.R.C.P.C. , Consultant in Neuropsychiatry (all)

Karen Rucas, B.Sc.OTReg(Ont); lecture appointment at the University of Toronto (all)

Dr. Chanth Seyone, MD., FRCPC, Director, ABI Clinic, Toronto Western Hospital, University Health Network, Assistant Professor, University of Toronto (Psychiatric Impairments)

Dr. Charles Tator, Founder of Thinkfirst Foundation of Canada and Neurosurgeon, TWH Senior Scientist, Division of Genetics & Development, Toronto Western Research Institute(Paraplegic/Tetraplegic, Traumatic Brain Injury in Adults, Paediatric Traumatic Brain Injury (Prior to 18))

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