Ontario Society of Occupational Therapists

Submission to FSCO 3 Year Review of Auto Insurance

March 2014

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Introduction

On behalf of occupational therapists working in the auto insurance sector in Ontario, the Ontario Society of Occupational Therapists (OSOT) appreciates the opportunity to provide input to the 3 Year Review of the Statutory Accident Benefits Schedule (the SABS). We understand the Government's mandate to ensure both affordability and availability of the insurance product, while at the same time preserving a strong Accident Benefits program to restore injured persons to their healthy pre-accident lifestyle. Without a readily accessible AB program, OSOT anticipates that this would lead to more severe and longer periods of disability for claimants along with an overflow of costs to Ontario's public health system and other social programs, and to weightier settlements on the Bodily Injury side.

The Ontario Society of Occupational Therapists (OSOT) is the voluntary professional association of over 3880 Ontario occupational therapists and occupational therapist students. Over 500 of the Society's members report practice in the province's auto insurance sector.

Occupational Therapists play a valuable role in returning injured persons to their prior occupations, whether these are at home, at work, at school or in the community at large. Occupational performance is the domain of occupational therapy and addresses an individual's ability to manage the day to day living skills that give purpose and meaning to life. The philosophical and theoretical underpinnings of occupational therapy lend an informed and congruent perspective to the government's goal: to assure that our auto insurance system balances a capacity to restore injured persons to their healthy pre-accident lifestyle with the delivery of a compensation system that fairly supports claimants when their injuries legitimately preclude their ability to function and earn a living.

An occupational therapy perspective, gathered from consultation with members who are both business owners and front line professionals in the sector, informs our comments to this review and drives our recommendations. The Society's comments are forwarded to identify opportunities and needs for system improvement and potential solutions and recommendations and are framed around 7 key themes.

1. *Attendant Care*
2. *The Minor Injury Guideline*
3. *Maintaining Competitive Fees in the Auto Insurance System*

4. *Addressing the need for Regular Review of Benefit Limits*
5. *Insurer Examination Timelines*
6. *Insurer Examination Standards*
7. *Application for Determination of Catastrophic Impairment*
8. *Clinic Registration/Licensure*
9. *HCAI Reporting*
10. *Stakeholder Engagement*

I. Attendant Care

Occupational Therapists are one of two professions who are able to assess claimants' attendant care needs and complete the Assessment of Attendant Care Needs (Form 1). OSOT is committed to supporting practice excellence amongst its members. To this end, OSOT has published a reflective practice resource manual for occupational therapists – *Supporting OT Practice in Ontario's Auto Insurance Sector – Assessment of Attendant Care Needs, Form 1: A Resource for Reflective Practice.* First published in 2009, this resource was revised and updated in 2011. The goal was to promote a uniform approach to client assessment and completion of the Form 1. Additionally, OSOT provides continuing education opportunities for its members to support their practice knowledge and currency with respect to the assessment of attendant care. The Society and the profession take the responsibility for assessment of attendant care benefits seriously.

As key stakeholders in the assessment and identification of need for attendant care benefits, OSOT and its members were surprised when new regulations relating to the benefit were introduced this year to be enacted February 1, 2014. The Society was not informed of issues of concern relating to the benefit, nor was there any consultation with stakeholders relating to the following changes;

> *Despite paragraphs 1, 2 and 3, if a person who provided attendant care services (the 'attendant care provider') to or for the insured person* ***did not do so in the course of the employment****, occupation or profession in which the attendant care provider would ordinarily have been engaged for remuneration, but for the accident, the amount of the attendant care benefit payable in respect of that attendant care* ***shall not exceed the amount of the economic loss sustained by***

the attendant care provider during the period while, and as a direct result of, providing the attendant care.

At this time, we raise the following points of concern with this new regulation and its implications for claimants, their families and access to attendant care that are identified by occupational therapists who observe and interact with claimants and their families regularly in relation to this benefit.

Family Members as Caregivers

Occupational therapists report the following typical reasons that family members assume attendant care roles:

- **The Attendant Care Benefit is insufficient to allow for purchase of the approved hours of attendant care based on real marketplace rates of attendants.**

  Prior to the change in the regulation, the benefit payable on the Form 1 was calculated based on the number of hours and level of care needed by an insured person from an attendant. The level of care was assigned a dollar value. This notwithstanding, it is commonly acknowledged that the fee rates for attendants listed on the Form 1 do not reflect market value and consequently, insureds are not able to purchase the same number of hours of care that has been approved on the Form 1 in the marketplace. For this reason, insureds often relied on family members to provide the care and they were compensated based on the Form 1 value.

- **Claimants prefer a family member to address attendant care needs**

  Given the personal nature of attendant care, many claimants prefer or require the care of family and friends over hired/contracted attendants with whom there is no relationship. This is especially common in the case of children and individuals with brain injuries. This is completely consistent with the SABS which reads:

  > *s.7 (c): an aide or attendant for a person includes a **family member or friend** who acts as the person's aide or attendant, even if the family member or friend does not possess any special qualifications;* (SABS)

- **Delays or disputes over attendant care benefit payments leave claimants with no resources with which to purchase attendant care**

  The ability of an insured person to purchase attendant care services can be confounded when attendant care payments are delayed and disputed. If the

client has insufficient financial resources to purchase attendant care services, this situation not only leaves the claimant without necessary support but unnecessarily places the insured person at risk of harm. Problems relating to disputed payments were identified in FSCO's 2009 5 Year Review. Recommendation 25 of this report addressed this in the following way:

> *The attendant care benefit should continue to compensate claimants for incurred expenses. However, to enhance consumer protection and transparency, the SABS could clarify that where an arbitrator has found that the insurer has been unreasonable in denying the attendant care benefit, payments should be made even if no expenses have been incurred.*

Limitation of Attendant Care Benefit to Family Members' Economic Loss

The 2014 amendments to the regulation now prohibit a family member from being paid the approved value of the attendant care benefit, but rather restrict payment to an amount that is equivalent to their economic loss. We identify the following problems with this practice:

a) **There is inequitable treatment of claimants who have family caregivers who were workers and those whose family caregivers were not employed prior to the accident and those who have family members that earn more than $750 a week and those that earn less. The current provisions unfairly discriminate against homemakers, retired persons, students and those that earn less than $750/week. For example, in a situation where a claimant required 40 hours care/week ;**
   - **when a family member earns $500/week the Attendant Care Benefit entitlement for that family member to provide care is approx. $2000**
   - **when a family member earns $1000/week the Attendant Care Benefit entitlement for that family member to provide care is $3000**
   - **when a family member does not work outside of the home the Attendant Care benefit entitlement for that family member to provide care is $0**

b) **Claimants will receive less compensation for attendant care or no compensation at all if they elect to have a family member provide care and the family member makes less than the amount approved per week for attendant**

care.

c) **The value of a family member as a caregiver is overlooked as the new provisions may not only incent external contracting of attendants but also minimize the financial value of a family member's caregiving in relation to market rates for equivalent services.**

Case Example

The concerns identified above are illustrated in the following case example.

The Situation…..

Mr. Jones is seriously injured (not currently deemed catastrophic) and requires care at 12 hours per day or 84 hours per week, 336 hours/month. The claimant's wife is employed and makes $15 per hour and works 20 hours per week = $300 per week or ~$1200 per month. The claimant's wife has stopped working 20 hours per week to look after her husband who needs 84 hours per week of care. She provides all the attendant care services.

Using the calculations of the Form 1, the cost of 84 hours of attendant care per week exceeds $3000 per month. In theory, this claimant has access to up to $3000/month to provide for his attendant care services. However, further to the February 2014 amendment, if a family member is providing all of the attendant care – then the maximum they would be compensated for is their loss of income up to a maximum of $3000. In this case, Mr. Jones would have access to $3000/month for attendant care if his wife does not provide the care, but only $1200/month if his wife decides to leave her job, support her husband and provide for his caregiving needs.

Scenario #1: Wife provides all the care

In this case example, the wife would be compensated $1200 (her loss of income at $300/week) for providing all the attendant care, even though:

- her husband has entitlement to $3000/month
- her husband requires 84 hours per week of care and, at her job, she only worked 20 hours per week
- at her job, she earned $15/hour; if as a caregiver she earned $15/hour she would be able to provide 80 of the 336 hours required by her spouse each month leaving a shortfall of paid care of 256 hours.
- as a caregiver for her husband, working 84 hours a week, with a $1200 maximum, she will earn the equivalent of $3.49/hour at this "job"

Scenario #2: Wife provides a portion of the care

Alternatively, she could choose to provide 20 hours of care/week (80 per month) paid at $1200/month and then hire an attendant to provide the remainder of care.

- in this case 64 hours per week (256/month) is subject to the remaining Form 1 limits ($1800) and the conditions set out in the SABS.
- The actual cost of care with a service provider at a market rate is approximately $28 per hour. Therefore, she would be able to purchase 16 hours of care /week (64/month) instead of the 64 hours per week of care that her husband requires.
- There would be a shortfall of paid care of 34 hours per week or 136 per month

Scenario #3: Claimant purchases all of the care

In this case, the amended SABS provides for up to $3000 of incurred expenses and the claimant could use these funds for the purposes of purchasing necessary attendant care services.

- At a market rate of $28/hour, the claimant could purchase 107 hours per month or 26 hours per week, even though his "need" is for 86 hours per week
- There would be a shortfall of paid care of 40 hours/week or 160 hours/month
- Claimant has forfeited choice to have family member provide care

Prior to the amendment, the wife provides all the care

In this case the claimant would have submitted his wife's hours of care for reimbursement up to the limit, i.e., $3000.

- The wife would provide 336 hours of attendant care per month (84 hours/week)
- Approximate compensation rate would be $8.93/hour

In addition to these significant limitations of the new policy, we highlight the following questions:

i. If a caregiver provides attendant care for an extended period of time, over which they would have been entitled to salary increases, will this be reflected in the submitted economic loss?

ii. Does the economic loss include the loss of benefits, seasonal overtime, vacation pay or bonuses, etc?

iii. How will opportunity costs/losses to the caregiver be evaluated in the circumstance when a teenager or adult has accepted a position (e.g. a summer job), but is unable to proceed to this job because they must now provide Attendant Care to their family member?

iv. If a family member chooses to reduce his/her hours at work to provide care, will they submit their partial hours for reimbursement?

v. Given that the Attendant Care benefit is paid directly to the claimant because the claimant has a contract with the insurance company, how will the insurer compel the attendant (who is not under an insurance contract) to divulge their personal income information?

vi. The Assessment of Attendant Care Needs (Form 1) recognizes three levels of care—some care is more basic while other care is more complex. Consequently, the hourly rate rises as the complexity of care (e.g. ventilator care) increases. Yet, in the model of payment based solely on economic loss, this payment structure and recognition of "levels" of care is lost despite the fact that the family member may be required to undergo training and assume greater risk when performing, for example, injections or tracheotomy care.

vii. We have been informed that if a family member becomes a PSW AFTER their family member has an injury in order to get paid for Attendant Care, they would, in fact, NOT be compensated for care as they would have had to have their PSW certificate prior to the accident. Is this accurate? What is the rationale for this position? position?

viii. There is a need to clarify whether this provision applies to claimants with injuries on or after February 1, 2014 or whether it now applies to all claims with injuries on or after September 2010.

OSOT suggests that insurers have seen significant savings as a result of the requirement for an "incurred expense" in order to receive payment for attendant care benefits as of September 1, 2010. We are unclear of the rationale for further control and benefit limitation. The latest February 1, 2014 change is not consistent with the considered opinion found in case law which recommends payment of attendant care based on the Form 1 and is, in our opinion, simply unfair for claimants and their families.

The Society, on behalf of our members, wishes to emphasize that these concerns and likely others would have been raised during a stakeholder consultation process had such a consultation been structured.

RECOMMENDATIONS:

1. **OSOT recommends that the requirement that access to the attendant care benefit be tied to an incurred expense be struck. This provision unfairly discriminates against the provision of attendant care services by a family member. This problem has been further exacerbated by the February 2014 amendments tying benefit to economic loss.**

2. **As long as an incurred expense is requirement, OSOT supports the FSCO recommendation of the Five Year Review report that the SABS should clarify that where an arbitrator has found that the insurer has been unreasonable in denying the attendant care benefit, payments should be made even if no expenses have been incurred.**

3. **In light of the cost saving measures implemented in the 2010 reforms and significant savings insurers have experienced with respect to the Attendant Care Benefit further to the requirement to demonstrate "incurred" expense, we query whether this latest amendment is targeted to address a perception that more insidious fraudulent activity occurs where an inflated Form 1 is secured and family members provide the care, drawing an income from the benefit until such a time as their claim is settled. If this is the motivation, we express concern that the action taken as a solution penalizes *all* claimants rather than addressing a more specific issue directly. As occupational therapists are central to the identification of need for attendant care services, the Society is concerned that if such perceptions exist that there be the opportunity and expectation that issues be explored and addressed in a manner that best protects the interest of the public. The regulated status of occupational therapists provides a meaningful public forum for addressing concerns relating to competence, unethical behavior, etc. We are unaware that concerns relating to the assessment of attendant care have been raised to the College of Occupational Therapists of Ontario and have not ourselves had issues raised by the industry. While we feel assured that occupational therapists practice ethically and to high standard, the Society extends its commitment to undertake any necessary measures to identify practices which are inconsistent with the intent of the Regulation or the standards of occupational therapy practice in Ontario and to continue to promote practice knowledge, skill and confidence in the assessment of need**

for attendant care benefits. We urge FSCO to work in partnership with the Society to address issues related to this benefit in an open, solutions focused manner.

II. The Minor Injury Guideline

The Minor Injury Guideline (MIG) was introduced in September 2010, with objectives to speed access to rehabilitation for persons who sustain minor injuries in auto accidents; improve utilization of health care resources; provide certainty around cost and payment for insurers and regulated health professionals; and be more inclusive in providing immediate access to treatment without insurer approval for those persons with minor injuries as defined in the SABS and set out in the Guideline. The MIG appears to be capturing approximately 70% of claimants. (*HCAI data between January 1-June 30th, 2011*).

Occupational therapists offer the following comments and observations relating to the about the MIG and identify opportunities for attention and improvement in the following four areas.

a) Embracing Alternative Evidence Based Models of Care

The intent of the reforms of 2010 was twofold; to bring about changes to *increase consumer choice* and to *stabilize auto insurance rates*. The MIG was one strategy that addressed stabilization of auto insurance rates with its goal to provide limits and certainty with respect to costs for treatment of minor injuries. As a model of care, however, the MIG has not evolved to address principles of consumer choice. Currently there is one prevailing model of care that is pervasive within the industry - clinic-based acute physical rehabilitation/pain management. Occupational therapists propose that the scientific evidence supports an alternative model, one that in OSOT's opinion, more effectively supports staying at work, staying engaged in day to day home and community based function and minimizes a claimant's focus on injury, disability and pain.

In line with current best practice and scientific literature, as well as the preliminary results of Pierre Coté's Minor Injury Treatment Protocol Project (*presented January 17, 2014 in Oshawa, Ontario*), the Society proposes consideration of an alternative option for MIG service delivery. This option would include 3 components:

1. **Continue to work/function campaign**
    i. Staying Active
2. **Self-directed management of symptoms**
    i. Exercise & Stretching
    ii. Relaxation & Stress Management
3. **Management of Yellow Flags/Psycho-social risk factors**

This model would be delivered in the home, school or workplace where the claimant needs to function and minimizes the need to pay for the costs of operating clinics. This transformational model supports continued engagement in one's life roles and minimal/no time away from work, both of which facilitate optimal functional outcomes, reduced costs of specified benefits such as income replacement benefits, fewer dollars spent in medical & rehabilitation benefits, and a recovered, satisfied insurance consumer.

RECOMMENDATION:

4. **That alternative service delivery models for evidence informed treatment and rehabilitation of claimants with Minor Injuries be explored in order to more effectively promote stay at work/function, timely recovery and cost efficiencies. OSOT would be pleased to discuss an evidence-informed work/home based model.**

Requirement for Documentation of Pre-existing Medical Condition

The regulatory changes relating to eligibility for the MIG effective February 1, 2014 now require that a pre-existing medical condition that will prevent the insured person from achieving maximal recovery from the minor injury if he or she is subject to the $3,500 limit be documented by a health practitioner before the accident in order for a claimant to be excused from the MIG.

OSOT asserts that this provision may unfairly restrict access to full benefit entitlement. Obtaining medical documentation that precedes the accident may be difficult for a number of reasons such as:

i. Gathering this information from specialist and family physician offices will require time, effort and funding; who is responsible to do this and fund it? Do these costs come out of the $3500?

ii. The condition which may exempt a person from the MIG may have existed but only come to light after the accident in question or may have been in the process of being investigated prior to the accident, however the final diagnosis and associated paperwork may not have been completed prior to the date of loss. In such cases there would be no pre-MVA documentation related to the newly discovered condition

iii. An individual may have suffered a medical condition at the time of the accident or just prior (for example a stroke or heart attack) that is identified further to the actual motor vehicle accident.

RECOMMENDATION:

5. **We recommend that the requirement for documentation of a pre-existing injury be repealed. OSOT positions that access to documentation should not be a barrier to care.**

Inclusion of non-MIG Claimants in Minor Injury Guideline

Occupational therapists working in the auto sector have been alarmed by a practice of insurers whereby, even persons with obvious non-MIG injuries are being forced to start their treatment in the MIG. It would appear that insurers wish to start treatment immediately and to confirm the diagnostic category later. In theory, this would seem reasonable so as not to delay necessary and timely treatment, however there are several concerns that arise from this practice which include:

1) Treatment in the MIG could exclude insureds from benefits and services deemed necessary such as Attendant Care and the provision of a Home Assessment as these benefits are not allowable under the Minor Injury Guideline.

2) Once placed in the MIG, there appears to be resistance from insurers to have the person access the standard level of funding, namely $50,000. Often, insureds must endure an unnecessary insurer evaluation(s) (IE) before they can move out of the MIG.

3) Moving out of the MIG may interrupt treatment and the person's overall progress in rehabilitation as he/she wait for IEs to be scheduled and for the

insurance company to receive the report(s) and finally to adjudicate on the matter.

RECOMMENDATIONS:

6. **OSOT recommends a FSCO audit to determine the prevalence of insurer practice to place non-MIG claimants in the MIG.**

7. **OSOT would propose that publicly accessible data through HCAI should allow for tracking of outcomes of MIG Insurer Examinations.**

Future Direction for development of the MIG

OSOT is concerned about the direction of the Minor Injury Treatment Protocol Project in relation to its consideration of diagnostic inclusion criteria. When the Pre-Approved Framework (PAF) was originally established, it considered neck pain with or without low back pain. When the MIG replaced the PAF, the mandate for this treatment protocol expanded to include all soft tissue injuries. There was no science available to support this approach; the review and exploration of the literature is yet to be completed. The Society is aware, from updates from the Minor Injury Treatment Protocol Project, that consideration of additional diagnoses including; mild traumatic brain injury, post-concussion syndrome, depression or other diagnostic categories outside of soft tissue injuries. The consideration of these more complex conditions to be treated in the MIG is concerning to occupational therapists.

RECOMMENDATION:

8. **OSOT asserts that the inclusion criteria for the Minor Injury Treatment Protocol should be limited to soft tissue injuries, as it was originally designed, with the emphasis on scientifically-based treatment options. This position endorses our understanding of the historical intent for focus on minor soft tissue injuries.**

III. Maintaining Competitive Fees in the Auto Insurance System

Occupational therapists working in the auto insurance sector have witnessed and personally experienced significant fiscal restraint over the years as stakeholders, FSCO and government have struggled to preserve both affordability and availability of the insurance product, while at the same time preserving a strong Accident Benefits program to restore injured persons to their healthy pre-accident lifestyle. By and large, providers have acknowledged the fiscal pressures of a recessive economy and the impacts on the insurance industry. However, reports of increasing profits and financial stability give cause to members expressing concern that while the sector continues to ask providers to do more (administrative costs of HCAI, licensure, etc.) there has been no concomitant attention to fees of professionals in the sector.

OSOT identifies a number of fees that have remained static since September 1, 2010 or earlier, and which do not reflect the current cost of living. These include:

i. $2000 assessment fee cap

ii. $3500 cap on the Minor Injury Guideline

iii. Professional Services Guideline (since 2012)

Assessment Fee Cap and the Minor Injury Cap

The government's decision to introduce a fixed $2000 fee cap was opposed by OSOT in 2010 given the anticipated problems it would create with the most complicated files; files that OTs are typically engaged in. Indeed, our experience over the past 3.5 years has actualized those concerns. This cap does not allow independent examiners to carefully review file material, travel, assess and write a thorough and defensible report for those claimants who are:

- Seriously injured adults and children
- Persons whose claim exceeds 2-3 years
- Persons who live in remote, under-serviced areas in Ontario or outside Ontario
- Claimants who have medically complex conditions/injuries

Insurers report they are not able to secure the appropriate experts to secure a specialist's report to lend further support and/or to provide a diagnosis, as these experts no longer accept SABS files as a result of the fee cap. The exodus of these experts has

created a void in this industry over the past 3.5 years, and has created significant disadvantage for insureds in their ability to access quality assessments and, ultimately, their benefits.

We believe the $2000 assessment cap now has a negative impact on business viability of professionals in the sector and on the quality and experience of professionals that can be retained in the sector. We position that a benefit driven system is best served by experienced professionals whose knowledge and skills lend efficiency to the system as well as quality assessments and treatment.

We note that FSCO noted this concern in its 5 Year Review of the system in 2009. The report notes, "*…experienced providers have been exiting the auto insurance system since fees were rolled back five years ago, leaving the system with a greater proportion of inexperienced providers. Unfortunately, FSCO did not have access to detailed information regarding health care provider manpower in the sector.* ***Recommendation #26: FSCO needs to continue to monitor fees and the availability of services in the auto insurance sector, in particular for seriously injured claimants."***

While FSCO routinely reviews insurer rates and checks on their business viability in Ontario, health care practitioners are not seeing yearly or bi-yearly reviews of rates. As OTs report falling further and further behind, challenged to maintain viability in the sector, we worry about retention and urge attention to small ways to incentivize professionals to stay in the sector.

Ensuring that sectoral rates and fees for service keep pace with the cost of living is one way to ensure that providers feel that the sector allows them to keep pace with the cost of doing business. The charts below reflect the gradual increase of fees for the Assessment cap and the Minor Injury Guideline cap if they were attached to the Ontario Consumer Price Index:

	Fee		0%Δ	Ontario CPI	
Year			Actual amount	Potential increase	%Δ
2010	Ax Cap	2000	**2000**	2000	**2.4**
2011			**2000**	2062	**3.1**
2012			**2000**	2091	**1.4**
2013			**2000**	2111.91	0.99 (until Aug)

	Fee		0%Δ	Ontario CPI	
Year			Actual amount	Potential increase	%Δ
2010	MIG Cap	3500	**3500**	3500	**2.4**
2011			**3500**	3584	**3.1**
2012			**3500**	3634	**1.4**
2013			**3500**	3670	0.99 (until Aug)

RECOMMENDATIONS:

9. **Annual adjustments based on the Ontario Consumer Price Index should be applied to the Assessment Fee Cap and the Minor Injury Fee Cap to ensure that fees keep pace with costs of doing business. Regular cost of living increases ensure that the sector is not at risk of more significant and required increases in any one year.**

10. **The cost of travel should be paid <u>outside</u> of the Assessment Cap so as not to disadvantage claimants living in more remote areas of the province or outside of the province when experienced professionals are not available locally.**

11. **Remove the Assessment Cap and/or provide additional funding for claimants with complex medical conditions and/or whose files are over 3 years old.**

<u>Professional Service fees</u>

When the Professional Services Guideline (PSG) was first published in 2003, resulting in a 30% cut in occupational therapists' fees, the Superintendent's Bulletin (A06/05) stated:

> *Annual Change in Professional Services Guideline:*
>
> *It is expected that the Professional Services Guideline will be <u>revised on an annual basis,</u> effective on July 1st each year, based on the recommended annual increase*

to the OMA Physician Guide to Third Party & Other Uninsured Services or another appropriate factor.
http://www.fsco.gov.on.ca/en/auto/autobulletins/2005/Pages/a-06_05.aspx

OSOT members were disappointed in 2013 when the Superintendent announced that he was not prepared to revise the hourly rate to keep step with inflation. While OSOT appreciates that the government has promised a 15% rate reduction to consumers, it appears to frontline OTs that health practitioners are shouldering a disproportionate share of this burden when major insurance companies are showing healthy returns on their investments.

To lend perspective to this issue, the following table reflects the hourly fee paid to occupational therapists over the past 18 years in relations to the profession's guideline.

YEAR	OSOT RATE per HOUR	PSG RATE per HOUR
1996	$95 to $120	N/A
2003	$104 to $130	$84.00 per hour
2009	$104 to $130 *	$94.09 (non CAT) $113.12 (CAT)
2014	$104 to $130 *	$98.86 (non CAT) $118.85 (CAT)

*note that the Society perceived sufficient range within the $104 - $130/hour to accommodate annual COLA adjustments in this time period.

Occupational therapists continue to advocate for attention to an unexplained differential in the fees for Speech Language Pathologists in the Professional Services Guideline. The 2013 Professional Services Guideline identifies the following fees for physiotherapists (PT), occupational therapists (OT) and Speech Language Pathologists (SLP).

	Non-Catastrophic	Catastrophic
Occupational Therapists	$98.86	$118.85
Physiotherapists	$98.86	$118.85
Speech Language Pathologists	$111.22	$132.97

It is unclear why the hourly fee for SLPs is 11% higher than that of PTs and OTs. These three professions are educated at the same Masters level and provide assessment and treatment interventions in the sector that are similar in focus and risk and responsibility.

RECOMMENDATIONS:

12. **Apply a 2013 CPI adjustment to the Professional Services Guideline immediately**

13. **Review the Professional Services Guideline in July 2014 and reflect a 2014 adjustment based on the Consumer Price Index.**

14. **Mandate annual rate revisions for rates within the Professional Services Guideline to reflect cost of living adjustments.**

15. **Adjust the hourly fees of physiotherapists and occupational therapists to align with the hourly fees for speech language pathologists.**

IV. Addressing the Need for Regular Benefit Limit Reviews

OSOT identifies a number of benefit limits that have remained static since September 1, 2010 or earlier, and which do not reflect adaptation to an increasing cost of living. These include:

1) Income Replacement Benefit Cap of $400
2) Claimant mileage cap of $0.37/km
3) $50,000 Medical Rehabilitation Benefit Cap
4) Attendant Care monthly benefit cap

Income Replacement Benefit

Despite the 5 Year Review recommendation to increase the Income Replacement benefit to $500 per week, the maximum basic coverage for income replacement remains at $400 per week or $20,800 per year. The average earnings for Canadian women and men in 2011 are $32,100 and $48,100 respectively (http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/labor01a-eng.htm) and this notwithstanding, the most recent Statistics Canada survey shows that Toronto

(where there are the highest percentage of motor vehicle accidents in Ontario) is the most costly city to maintain a home in the entire country. Basic insurance coverage has simply not kept step with the actual cost of living for Ontarians.

Claimant Mileage Reimbursement

Since 2010, mileage reimbursement has only been accessible for claimants who have a catastrophic designation. The current rate of reimbursement is $0.37/km. This rate of reimbursement is widely out of step with CAA rates as seen in the 3 tables in the attached Addendum. (*2013 CAA Driving Costs*). The Society supports a recommendation made in the last 5 Year Review which read: *"Conduct annual review of reimbursement rate for travel in a personal vehicle."* We are concerned that this appears not to have been undertaken resulting in a reimbursement rate that is approximately 25% lower than current CAA rates.

RECOMMENDATIONS:

16. That FSCO undertake a complete review of benefit levels in the sector and consider the following to inform such a review;

- **a) How many Ontarians opt to purchase optional income replacement coverage or any of the other options available;**
- **b) Average income rates and costs of living in Ontario;**
- **c) The actual costs to drive a vehicle to provide fair and current mileage reimbursement.**
- **d) The actual costs for delivering attendant care.**

17. That the government consider an increase to:

- **a) the basic level of income replacement coverage to provide consumers with a fair starting point and the ability to pay their basic expenses in the event of accident and injury. Note: This particular benefit, while it currently maxes out at $400 per week, is actually determined as 70% of the claimant's gross salary.**
- **b) Mileage reimbursement to reflect actual costs.**
- **c) Attendant care benefits.**

Medical/Rehabilitation $50,000 Cap

The Medical/Rehabilitation Benefit is capped at $50,000 for claimants who are not deemed catastrophic and covers all **medical, rehabilitation, medications, social, vocational, life skills counseling, equipment, home modifications, work modifications, vehicle modifications and transportation fees** for the claimant. This benefit was reduced from $100,000 (a benefit limit set in 1996) to $50,000 in 2010. OSOT members vigorously opposed this move by government for fear that patients with serious but not catastrophic injuries would run out of funds before their rehabilitation potential was achieved.

Like all other fees embedded in the SABS, this fee has not seen any increase in 3.5 years. While costs continue to increase, as evidenced by a positive CPI over the past 3.5 years, this fee cap continues to fall further and further behind. OSOT members report that seriously injured patients are exhausting the $50,000 fee cap before their rehabilitation has been completed, and before they have returned to work or function.

While annual cost of living adjustments do not provide for materially *more* rehabilitation, they do ensure that the relative value of the benefit remains relevant to the cost of living and helps ensure that the basic level of access is maintained. The following table reflects the application of a cost of living adjustment to the Med/Rehab Fee cap.

	Fee		0%Δ	Ontario CPI	
Year			Actual amount	Potential increase	%Δ
2010	Med/Rehab cap	50,000	**50,000**	50,000	**2.4**
2011			**3500**	51,550	**3.1**
2012			**3500**	52,271	**1.4**
2013			**3500**	52,794	0.99 (until Aug)

RECOMMENDATIONS:

18. **Review of the number of claimants that exhaust the $50,000 cap either via HCAI or via data collected by insurers.**

19. **Review current med/rehab benefit limits with a goal to increasing, at a minimum incorporating a retroactive adjustment based on the Consumer Price Index to 2010.**

20. **Determine a yearly increase to the $50,000 med/rehab cap as per the Ontario CPI, which will fairly capture the increase in costs related to this benefit.**

V. Insurer Examinations – timelines and standards

Prior to September 1, 2010, when an insurer declined an OCF-18/Treatment and Assessment Plan for goods, services and examinations, an Insurer Examination (IE), typically performed by a peer, was mandatory. Strict timelines were in place to safeguard that the Insurer Examination was promptly scheduled and conducted, and that a report was generated in a timely manner. If the insurer did not meet this timeline, the plan was deemed approved until such a determination was given s.38(17)(a) and (17.1)2.

Presumably insurers found the deadlines too restrictive. Consequently, the timelines were removed in the Regulation as detailed below.

Timeline for insurer to schedule an Insurer Examination and Produce the Insurer Examination Report		
PROCESS	**SABS Prior to Sep 2010**	**SABS Post Sept 2010**
OCF-22/OCF-18 submitted to Insurer for an assessment/treatment or other goods and services	Insurer has 3 business days to respond to the OCF-3 and 10 business days to respond to the OCF-18. If insurer fails to respond, the OCF-22/OCF-18 is deemed approved on the 11th day until the day the insurer gives notice s.38(8.2)2	Insurer has **3 business days to respond** to the OCF-3 and 10 business days to respond to the OCF-18. If insurer fails to respond, the OCF-22/OCF-18 is deemed approved on the 11th day until the day the insurer gives notice s.38(8.2)2
Time to provide notice of an IE	Insurer has 5 business days to provide claimant notice of	**NONE** Insurer shall give notice of examination

	exam s.42(5)(b)	s.44(5). If the attendance of the claimant is required at the examination, the insurer shall give the notice not less than 5 business days before the examination s.44(6).
Time for insurer to arrange assessment	5-10 business days	**NONE**

Time for the IE examiner to prepare the report	10 business days from the date of the exam and deliver to the insurer s.42(11)3(ii)	**NONE**
Time for insurer to provide IE report/determination to claimant	5 business days of insurer receiving report s.38(13)	Within 10 days of insurer receiving the report from the examiner s.36(7)
Total	**35 business days**	**Unlimited**

OSOT believes that the IE process, as set out in the current SABS, does not allow for a fair and timely adjudication of the injured person's claim; it is not fair to consumers who have entered into an insurance contract to obtain goods and services, when the process for application to benefit itself gets in the way. Our concerns are identified in the following points;

1. The Determination of the need for an IE is determined by insurance personnel who have neither medical nor rehabilitation background to guide this decision-making.

2. The elimination of legislated timelines at key points in the Insurer Examination process along with the removal of any requirement for the insurer to pay for the requested goods and services proposed in the OCF 18 if the IE report is not produced expeditiously leaves claimants vulnerable. Many claimants wait for extended periods of time for either the IE to be scheduled or for the determination/outcome of the assessment, all of which leads to unnecessary delays in treatment and recovery.

3. Most insurers adhere to the mandated deadline of 10 business days to respond to the OCF-18 via HCAI (38(8)), and many are providing claimants with a notice of at least 5 business days of the insurer examination date. Many insurers, however, are not setting the actual date for the insurer examination in a timely manner and/or are not retrieving the IE report in order to deliver their determination within a reasonable timeframe. Isn't this the same as above ….just need to add impact to claimant?

4. The only timeline left which the insurer must adher to is stated in Section 38 of the SABS (below) but is of little consequence as the claimant has no way to confirm when the insurer actually receives the IE report.

> *(13) Within 10 business days after receiving the report of an examination conducted under section 44 for the purpose of the treatment and assessment plan, the insurer shall give a copy of the report to the insured person and to the regulated health professional who prepared the treatment and assessment plan.*
>
> *(14) Within 10 business days after receiving the report, the insurer shall,*
>
> *(a) provide the insured person with a notice indicating the goods and services described in the treatment and assessment plan that the insurer agrees to pay for, the goods and services the insurer refuses to pay for and the medical and any other reasons for the insurer's decision; or*

5. For individuals who sustain serious injuries from motor vehicle accidents, a return to their pre-accident activities of normal life in a safe environment, and progress in their rehabilitation is dependent upon expeditious access to adequate and uninterrupted rehabilitation services. Lengthy delays in making a determination of entitlement to these services means claimants are left at risk and unnecessarily go without required benefits or treatment for long periods at a very critical time in their recovery. In some especially egregious cases, members report that insurers are taking more than a year to produce an IE report that has ultimately determined that the requested good or service was reasonable and necessary.

   Since insurers are no longer required to pay for goods and services when there are delays, there is little impetus for the insurer to adhere to reasonable timelines.

6. Although FSCO's dispute resolution process is available to claimants who do not wish to wait for the results of an IE before filing for mediation, this is not an expeditious route given the long wait times for mediation and arbitration. Furthermore, this tends to force claimants to obtain a lawyer, which can impede the process further.

7. After September 1, 2010, an insurer is required to provide "**the medical and any other reason**" (s.38(8)) why the insurer considers any goods, services, assessments, and examinations requested on an OCF-18 to be deemed not reasonable and necessary. Unfortunately, some insurers do not provide the medical and other reason, and do not schedule an IE; if they do provide a reason, it is delivered to the

claimant and not always copied to the health practitioner.

8. In the event that an IE is scheduled, there is little consistency and no specified requirement that a like professional will evaluate the client and proposed treatment and assessment plan of another professional. Occupational therapists position that it is not possible for another health professional, for example, a psychologist or family physician or psychiatrist to make comments on proposed functional equipment or occupational therapy treatment recommendations.

RECOMMENDATIONS:

21. As insurers have the sole authority to deny benefits and decide whether or not to request their own examination and to select the expert who is performing the evaluation, it is imperative that insurers are held to a reasonable timeline in the IE process in terms of both arranging the assessment after a denial and for delivering a determination.

22. In the HCAI system, we recommend removing the option "not reasonable and necessary" from the choices provided to insurers to deny an Treatment and Assessment Plan (OCF-18).

23. OSOT recommends that examinations should be performed by 'like' professionals. In other words, if an Occupational Therapist submits a Treatment and Assessment Plan, then in all likelihood, another Occupational Therapist is best suited to comment on the proposed treatment or equipment.

VI. Insurer Examinations - Standards

Judge Cunningham reviewed the Dispute Resolution system and commented on the quality of Insurer Examinations in February of this year. He stated:

> *"….IE assessors working in the auto insurance system have no standard assessment protocols, report formats or timelines, and I imagine it must be a challenge to insulate themselves from outside influence.*

In addition, in the 2009 five-year review of automobile insurance, the Superintendent recommended that health care professional associations and the insurance industry jointly develop standards for the delivery of third-party medical examinations, as well as qualifications for assessors. I understand that this recommendation has not been implemented to date."

RECOMMENDATION:

24. OSOT supports immediate attention to the development of standards for insurer assessments in the auto insurance sector to support quality and consistency in the Insurer Examination product and expresses interest and commitment to be engaged in this process of development.

VII. Application for Determination of Catastrophic Impairment

A catastrophic (CAT) impairment is an extremely serious impairment or combination of impairments that is expected to be permanent and which severely impacts an individual's ability to function independently. Prior to September 1, 2010, health practitioners, as defined in the SABS, were permitted to complete and sign an Application for Determination of Catastrophic Impairment (OCF-19).

The OCF-19 application does not definitively determine catastrophic designation, but is simply an "application" for the insurer to examine in considering the person being catastrophic or not. In many cases, the claimant's condition is self-explanatory, e.g. paraplegia, tetraplegia, amputation, blindness, GCS of 9 or under. In other circumstances, the insurer may wish to challenge the application by doing their own examinations.

As of September 1, 2010, in order to be assessed to determine if a client is catastrophically injured, he/she must have a medical doctor or, in the case of brain injury, a neuropsychologist, sign an OCF-19 application:

> (*5) Clauses (2) (e) and (f) do not apply in respect of an insured person who sustains an impairment as a result of an accident unless,*

(a) a physician or, in the case of an impairment that is only a brain impairment, either a physician or a neuropsychologist states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or

(b) two years have elapsed since the accident.

This change to the SABS was in response to concerns raised about healthcare professionals completing OCF-19s who were not properly trained in the application of the American Medical Association (AMA) Guideline 4th edition and were not qualified to complete this form. Inappropriate submissions of the OCF-19 would then force insurers to respond and complete an expensive CAT assessment.

Most family doctors, surgeons and specialists are not familiar with the (AMA) Guidelines 4th edition or the Ontario auto insurance claims process, including the CAT/ Non-CAT disability criteria in Ontario. As a result OCF-19's continue to be completed incorrectly. Occupational therapists report that they frequently experience physicians unwilling to complete the OCF-19 or require explanation/orientation to the form and the criteria of the AMA Guidelines. In such cases, claimants and their treatment team are forced to search for a physician that is both knowledgeable about the application, and also able to assess the client to complete the OCF 19.

Lack of access to a sufficient physician pool to complete the OCF-19 results in unnecessary delays, added expense and/or never getting the OCF-19 completed and consequently, limiting the seriously injured claimant's access to necessary benefits.

In such cases, what typically occurs is that a claimant is forced to retain legal representation to facilitate access to their benefits provided their lawyer is willing to pay for a physician to sign the OCF 19.

RECOMMENDATION:

24. Engage health care practitioners, as defined in the SABS (s. 3(1)), to complete and sign the OCF-19 provided the health care practitioner can demonstrate that he/she has the required training and knowledge of the AMA guides, and has passed the certification examination on the AMA guides 4th Edition, given in Ontario

VIII. Clinic Registration/Licensure

OSOT is supportive of efforts to eradicate fraud in the auto insurance system and has recognized that clinic registration or licensing is one measure to address a range of concerns addressed by the Anti-Fraud Task Force. We remain assertive in our concern, however, that licensing requirements fairly recognize the range of service providers in the sector and that the requirements not impose such onerous requirements or expense upon small businesses or single providers that their capacity to continue to operate in the sector is challenged. There exists a range of occupational therapy providers in the sector from large service provider companies to sole practitioners. All will wish to demonstrate their accountability to standards, however, the potential costs, time commitments and procedural requirements may be more demanding for smaller providers. We are concerned that licensure requirements could result in

Although the development of regulations to engage licensure is well underway, the Society is unable to meaningfully comment on proposed directions and requirements. The lack of fulsome consultation during the development and operational planning for implementation of these regulations has restricted health provider input to representation from the Coalition of Associations in Auto Insurance (of which OSOT is a member) to the Service Provider Business Licensing Implementation Forum. While OSOT is respectful of our representatives, they are unable to relay detail about the evolving process as a result of confidentiality limitations. Without this information, it is difficult for associations to provide effective guidance to the representatives to ensure that issues that may be unique to a profession's practice are addressed.

RECOMMENDATION:

26. OSOT participated in the development of recommendations submitted by the Coalition of Regulated Professional Associations in Auto Insurance relating to the licensure of clinics and health care providers and supports these recommendations.

IX. HCAI Reporting

The Coalition of Regulated Health Professional Associations in Auto Insurance has 3 representatives on the HCAI Committee and has contributed to the formation of HCAI for several years. The Coalition members have consistently expressed the following concerns with respect to the collection and reporting of data:

1) The "Non-MIG" data reflects both MIG-only patients (those who by means of an OCF-18, accessed the remainder of the $1300 left in the minor injury cap) and non-MIG patients. This must be rectified.

2) There is no method of collecting information for med/rehab fees paid to physicians for completing the OCF-3; medications; equipment; home modifications; vehicle modifications; and others. We have never been reassured that insurers are obliged to enter this information through a different portal.
3) The HCAI data tells us if an OCF-18 has been denied by an Insurer, but there is no information via HCAI that informs us as to 1) if it was sent to an IE and 2) the outcome of the IE.

4) OCF-19s should be tracked via HCAI.

RECOMMENDATION:

27. OSOT supports the recommendations forwarded as a component of the Coalition of Regulated Health Professional Associations in Auto Insurance

X. Stakeholder Engagement in Auto Insurance System Development

OSOT members have expressed concern around the recent release of regulations and amendments of the SABS and have questioned OSOT's support of these changes. We have had to identify that the Society has not been involved in consultation or development processes for these regulatory changes. With respect to the recently released amendments related to Attendant Care, the Minor Injury Guideline (to be

enforced as of February 1, 2014), it appears that insurers may have identified specific issues in relation to these three benefits which catalyzed amendments. It does not appear, however, that other stakeholders, who work closely with claimants and their families, were equally consulted prior to the development and release of these new Regulations. As noted in the Attendant Care and MIG sections above, there are numerous pitfalls relating to the February 1, 2014 regulatory changes which may have been averted had broad consultation taken place.

RECOMMENDATION:

28. **An inclusive consultation process to both identify potential solutions to real problems and to vet recommended amendments promotes collaborative problem solving, stakeholder engagement and support and, we believe, more effective implementation of changes that emerge from the process. By engaging in a rigorous, meaningful dialogue with stakeholders, there is greater potential to develop and implement sound Regulations that achieve the goal of consumer and cost protection.**

The Ontario Society of Occupational Therapists extends an ongoing commitment to contribute to issue identification and solution focused consultation, discussion and problem solving. Please contact Christie Brenchley, Executive Director for clarification of any points in this submission or for further debate or discussion of our input.

APPENDIX A – SUMMARYOF OSOT'S RECOMMENDATIONS

1. OSOT recommends that the requirement that access to the attendant care benefit be tied to an incurred expense be struck. This provision unfairly discriminates against the provision of attendant care services by a family member. This problem has been further exacerbated by the February 2014 amendments tying benefit to economic loss.

2. As long as an incurred expense is requirement, OSOT supports the FSCO recommendation of the Five Year Review report that the SABS should clarify that where an arbitrator has found that the insurer has been unreasonable in denying the attendant care benefit, payments should be made even if no expenses have been incurred.

3. In light of the cost saving measures implemented in the 2010 reforms and significant savings insurers have experienced with respect to the Attendant Care Benefit further to the requirement to demonstrate "incurred" expense, we query whether this latest amendment is targeted to address a perception that more insidious fraudulent activity occurs where an inflated Form 1 is secured and family members provide the care, drawing an income from the benefit until such a time as their claim is settled. If this is the motivation, we express concern that the action taken as a solution penalizes *all* claimants rather than addressing a more specific issue directly. As occupational therapists are central to the identification of need for attendant care services, the Society is concerned that if such perceptions exist that there be the opportunity and expectation that issues be explored and addressed in a manner that best protects the interest of the public. The regulated status of occupational therapists provides a meaningful public forum for addressing concerns relating to competence, unethical behavior, etc. We are unaware that concerns relating to the assessment of attendant care have been raised to the College of Occupational Therapists of Ontario and have not ourselves had issues raised by the industry. While we feel assured that occupational therapists practice ethically and to high standard, the Society extends its commitment to undertake any necessary measures to identify practices which are inconsistent with the intent of the Regulation or the standards of occupational therapy practice in Ontario and to continue to promote practice knowledge, skill and confidence in the assessment of need for attendant care benefits. We urge FSCO to work in partnership with the Society

to address issues related to this benefit in an open, solutions focused manner.

4. That alternative service delivery models for evidence informed treatment and rehabilitation of claimants with Minor Injuries be explored in order to more effectively promote stay at work/function, timely recovery and cost efficiencies. OSOT would be pleased to discuss an evidence-informed work/home based model.

5. We recommend that the requirement for documentation of a pre-existing injury be repealed. OSOT positions that access to documentation should not be a barrier to care.

6. OSOT recommends a FSCO audit to determine the prevalence of insurer practice to place non-MIG claimants in the MIG.

7. OSOT would propose that publicly accessible data through HCAI should allow for tracking of outcomes of MIG Insurer Examinations.

8. OSOT asserts that the inclusion criteria for the Minor Injury Treatment Protocol should be limited to soft tissue injuries, as it was originally designed, with the emphasis on scientifically-based treatment options. This position endorses our understanding of the historical intent for focus on minor soft tissue injuries.

9. Annual adjustments based on the Ontario Consumer Price Index should be applied to the Assessment Fee Cap and the Minor Injury Fee Cap to ensure that fees keep pace with costs of doing business. Regular cost of living increases ensure that the sector is not at risk of more significant and required increases in any one year.

10. The cost of travel should be paid outside of the Assessment Cap so as not to disadvantage claimants living in more remote areas of the province or outside of the province when experienced professionals are not available locally.

11. Remove the Assessment Cap and/or provide additional funding for claimants with complex medical conditions and/or whose files are over 3 years old.

12. Apply a 2013 CPI adjustment to the Professional Services Guideline immediately

13. Review the Professional Services Guideline in July 2014 and reflect a 2014 adjustment based on the Consumer Price Index.

14. Mandate annual rate revisions for rates within the Professional Services Guideline to reflect cost of living adjustments.

15. Adjust the hourly fees of physiotherapists and occupational therapists to align with the hourly fees for speech language pathologists.

16. That FSCO undertake a complete review of benefit levels in the sector and consider the following to inform such a review;
    a) How many Ontarians opt to purchase optional income replacement coverage or any of the other options available;
    b) Average income rates and costs of living in Ontario;
    c) The actual costs to drive a vehicle to provide fair and current mileage reimbursement.
    d) The actual costs for delivering attendant care.

17. That the government consider an increase to:
    a) the basic level of income replacement coverage to provide consumers with a fair starting point and the ability to pay their basic expenses in the event of accident and injury. Note: This particular benefit, while it currently maxes out at $400 per week, is actually determined as 70% of the claimant's gross salary.
    b) Mileage reimbursement to reflect actual costs.
    c) Attendant care benefits.
    d) Review of the number of claimants that exhaust the $50,000 cap either via HCAI or via data collected by insurers.

18. Review of the number of claimants that exhaust the $50,000 cap either via HCAI or via data collected by insurers.

19. Review current med/rehab benefit limits with a goal to increasing, at a minimum incorporating a retroactive adjustment based on the Consumer Price Index to 2010.

20. Determine a yearly increase to the $50,000 med/rehab cap as per the Ontario CPI, which will fairly capture the increase in costs related to this benefit.

21. As insurers have the sole authority to deny benefits and decide whether or not to request their own examination and to select the expert who is performing the evaluation, it is imperative that insurers are held to a reasonable timeline in the IE process in terms of both arranging the assessment after a denial and for delivering a determination.

22. In the HCAI system, we recommend removing the option "not reasonable and necessary" from the choices provided to insurers to deny an Treatment and Assessment Plan (OCF-18).

23. OSOT recommends that examinations should be performed by 'like' professionals. In other words, if an Occupational Therapist submits a Treatment and Assessment Plan, then in all likelihood, another Occupational Therapist is best suited to comment on the proposed treatment or equipment.

24. OSOT supports immediate attention to the development of standards for insurer assessments in the auto insurance sector to support quality and consistency in the Insurer Examination product and expresses interest and commitment to be engaged in this process of development.

25. Engage health care practitioners, as defined in the SABS (s. 3(1)), to complete and sign the OCF-19 provided the health care practitioner can demonstrate that he/she has the required training and knowledge of the AMA guides, and has passed the certification examination on the AMA guides 4th Edition, given in Ontario

26. OSOT participated in the development of recommendations submitted by the Coalition of Regulated Professional Associations in Auto Insurance relating to the licensure of clinics and health care providers and supports these recommendations as submitted by the Coalition.

27. OSOT supports the recommendations forwarded as a component of the Coalition of Regulated Health Professional Associations in Auto Insurance submission relating to HCAI reporting requirements.

28. An inclusive consultation process to both identify potential solutions to real problems and to vet recommended amendments promotes collaborative problem solving, stakeholder engagement and support and, we believe, more effective implementation of changes that emerge from the process. By engaging in a rigorous, meaningful dialogue with stakeholders, there is greater potential to develop and implement sound Regulations that achieve the goal of consumer and cost protection.

APPENDIX – CAA Annual Driving Costs 2014

ANNUAL DRIVING COSTS – based on the **Civic LX**				
Km driven per year	Annual operating costs (variable)	Annual ownership costs (fixed)	Total cost	Cost per km
12,000 km	$1,548.00	$6,175.72	$7,723.72	$0.64
16,000 km	$2,064.00	$6,439.72	$8,503.72	$0.53
18,000 km	$2,322.00	$6,439.72	$8,761.72	$0.49
24,000 km	$3,096.00	$6,691.72	$9,787.72	$0.41
32,000 km	$4,128.00	$7,171.72	$11,299.72	$0.35

ANNUAL DRIVING COSTS – based on the **Camry LE**				
Km driven per year	Annual operating costs (variable)	Annual ownership costs (fixed)	Total cost	Cost per km
12,000 km	$2,001.60	$7,140.52	$9,142.12	$0.76
16,000 km	$2,668.80	$7,450.00	$10,118.80	$0.63
18,000 km	$3,002.40	$7,450.00	$10,452.40	$0.58
24,000 km	$4,003.20	$7,752.52	$11,755.72	$0.49
32,000 km	$5,337.60	$8,316.52	$13,654.12	$0.43

ANNUAL DRIVING COSTS – based on the **Equinox LT**				
Km driven per year	Annual operating costs (variable)	Annual ownership costs (fixed)	Total cost	Cost per km
12,000 km	$1,972.80	$8,492.32	$10,465.12	$0.87
16,000 km	$2,630.40	$8,792.32	$11,422.72	$0.71
18,000 km	$2,959.20	$8,792.32	$11,751.52	$0.65
24,000 km	$3,945.60	$9,068.32	$13,013.92	$0.54
32,000 km	$5,260.80	$9,584.32	$14,845.12	$0.46