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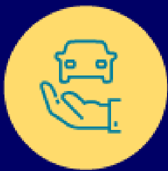

Consultation Paper

Statutory Accident Benefits Schedule (SABS) Guidelines Review

September 2024

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Executive Summary and Background

The Financial Services Regulatory Authority of Ontario ("**FSRA**") was launched in June 2019, as an independent regulatory agency established to improve consumer, credit union member and pension beneficiary protection in Ontario. FSRA serves the public interest by protecting these constituents and also by fostering a strong, stable, competitive and innovative auto insurance sector.

In supervising and regulating the auto insurance sector, FSRA is guided by its statutory objects under section 3(2) of the *Financial Services Regulatory Authority of Ontario Act, 2016* ("***FSRA Act***").

A review of Guidelines incorporated by reference into O. Reg. 34/10: Statutory Accident Benefits Schedule (SABS) supports and aligns with the following FSRA statutory objects:

- contribute to public confidence in the insurance sector
- protect the rights and interests of insurance consumers
- deter deceptive or fraudulent conduct, practices or activities by the insurance sector
- promote high standards of business conduct in the insurance sector
- protect the rights and interests of consumers
- foster a strong, sustainable and competitive insurance sector

In its 2024 Ontario Budget[1], the Government committed to move forward with auto insurance reforms. As part of the Budget commitment, the Government requested that

[1] The Budget also introduced two other reforms that indirectly impact the SABS Guidelines review. First Payor: proposing to make auto insurance pay for medical and rehabilitation benefits following an accident first instead of extended health care plans; and Benefit Optionality: proposing that mandatory auto insurance accident benefit coverage will continue to apply to medical, rehabilitation and attendant care benefits, while all other benefits would become optional.

FSRA conduct a review of the Professional Services Guideline ("**PSG**") and Attendant Care Hourly Rate Guideline ("**ACHRG**"). As part of this review, FSRA is also reviewing the health service provider ("**HSP**")[2] fees in the Minor Injury Guideline ("**MIG**").

This Consultation Paper is part of FSRA's review of the SABS Guidelines and sets out options that fall within FSRA's statutory authority to implement and advance the Government's commitment to improve Ontario's auto insurance system.

Purpose of Consultation, Desired Outcomes and Next Steps

In Ontario, there are 5,008 licenced HSPs which provide medical and rehabilitation treatment for consumers.[3] Medical and rehabilitation costs are a major component of the total cost of auto insurance claims (*see Appendix A - Auto Insurance Claims*). The primary drivers behind medical and rehabilitation costs are the fees that HSPs charge for goods and services. FSRA is reviewing the HSP rates and fees set out in the following SABS Guidelines:

1. Professional Services Guideline ("**PSG**")

2. Attendant Care Hourly Rates Guideline ("**ACHRG**")

3. Minor Injury Guideline ("**MIG**")

In undertaking its review of the rates/fees set out in the three SABS Guidelines, FSRA has prioritized the following key principles of maintaining the care that consumers receive and ensuring the continued availability of services (*aligns with FSRA's object of protecting the rights and interests of auto insurance consumers*).

[2] Depending on the Guideline the term "health service provider" may have a more narrow or more expansive definition. For the purposes of this paper "health service providers" or "HSPs" is used for all three Guidelines, although a more precise definition for each Guideline is also provided.

[3] Number of active HSP licenses as of August 28, 2024, is 5,008.

The desired outcome of this review, for both the Government and FSRA, is to ensure that those injured in auto accidents continue to receive the care they need and that HSPs are compensated appropriately for their services.

To achieve the desired outcomes, FSRA is seeking stakeholder feedback on how to best serve Ontario consumers. The feedback received will assist FSRA in better understanding the benefits/disadvantages of the approach taken and options proposed in this Consultation Paper. FSRA is also seeking data and evidence to further validate the stakeholder feedback outlined in this Paper.

This Consultation Paper is the first step of a multi-step process which is being taken to review the three SABS guidelines. The stakeholder feedback and data/evidence obtaining during both public and targeted consultations is the next step. Finally, this feedback will be used by FSRA to further develop and refine its final SABS Guidelines review recommendations.

Legislative and Regulatory Framework

FSRA is responsible, under the *Auto Insurance Rate Stabilization Act*, 2003, for approving, rejecting, or requesting variance in proposed automobile insurance rates based on whether they meet statutory standards (i.e. rates that are just and reasonable and not excessive). This piece of legislation is important given that the rates/fees found in the SABS Guidelines have an impact on the rates that insurers charge consumers.

Pursuant to s. 268.3 (1) of the *Insurance Act (*the *"**Act**")*, the Chief Executive Officer of FSRA ("**CEO**") can issue guidelines on the interpretation and operation of the SABS or any provision of that Schedule.

The PSG and MIG are incorporated by reference into the SABS under the definitions of "Guidelines." As such, they are formally part of the SABS regulation and carry "the force of law." The ACHRG is issued pursuant to s. 268.3 of the *Act* and is incorporated by reference in subsection 19 (2) (a) of the SABS.

SABS Guidelines Review Options and Analysis

The review of the three SABS Guidelines was driven by balancing the key principles of maintaining the care that consumers receive while also ensuring the continued availability of services. The desired outcome of the options proposed in this Consultation Paper is to ensure that those injured in auto accidents continue to receive the care they need and that health service providers are compensated appropriately for their services.

Professional Services Guideline (PSG)

Purpose

The PSG was first issued on September 18, 2003, by the legacy regulator, the Financial Services Commission of Ontario ("**FSCO**"), pursuant to section 268.3 of the *Act*, and was incorporated by reference into the SABS (see s.15(2), 16(4)(a), 17 (2) and 25(3)).

Prior to 2003, fee-setting was essentially left to the market as parties were allowed to set and negotiate rates between themselves. Auto insurers led the call to establish fee schedules for HSPs to provide greater uniformity and to stabilize costs. In 2003 when the new PSG was issued, it had the impact of reducing the fees in the existing schedule and introducing hourly rates. Since 2003 HSP fees have been updated on a periodic basis based on the consumer price index ("**CPI**").

The maximum hourly rates in the PSG only apply to consumers receiving health care services that are classified as non-catastrophic or catastrophic. The PSG does not apply to consumers with injuries that fall within the definition of "minor", which are captured by the MIG. Health care services covered by the PSG includes chiropractic, massage therapy, occupational therapy, physiotherapy, podiatry, psychology, speech therapy, nursing and kinesiology etc. The purpose of the PSG is to establish maximum hourly rates that automobile insurers are liable to pay to the listed HSPs in relation to medical and rehabilitation benefits received by a consumer (*see Appendix B for a complete list of HSPs*

covered under the PSG).[4] The PSG also includes maximum rates payable to HSPs for case management services, the costs of examinations, assessments, report writing and other matters.

The rates and fees found in the PSG include all administration costs, overhead, and related costs, fees, expenses, charges and surcharges. Insurers are not liable for any administration or other costs, overhead, fees, expenses, charges or surcharges that increase the rate/fee, beyond what is permitted under the PSG. The PSG is also subject to the prescribed standard limits in place for medical and rehabilitation ($65,000 for non-catastrophic and $1 million for catastrophic). Review of these legislated prescribed limits are outside the scope of this Consultation Paper.

Not all health services or professions who treat accident benefit consumers are listed in the PSG. HSPs not listed with a corresponding fee in the PSG can determine or negotiate fees payable with insurers. Insurers are not prohibited from paying above the maximum amounts or hourly rates established in the guideline although data provided by stakeholders suggests this does not usually happen.[5] Similarly, consumers can agree to pay more and HSPs can decide to charge lesser amounts.

Historical Indexation

The PSG rates and fees were reviewed annually by FSCO, and they were updated at the discretion of FSCO's Superintendent of Financial Services[6]. FSCO did not have a legal obligation to review or increase the PSG rates and fees on a regular basis, nor does FSRA.

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[4] A medical benefit under clauses 15 (1) (a), (b), or (h) of the SABS; a rehabilitation benefit under clauses 16 (3) (a) to (g) or (l) of the SABS; case management services under subsection 17 (1) of the SABS; or conducting an examination, assessment or provision of a certificate, report or treatment plan under subsection 25 (1) 3 of the SABS.

[5] A pilot undertaken by Ontario Rehabilitation Alliance suggests that only in 34% of cases were rates higher than the PSG prescribed rates approved in Treatment Plans by insurers.

[6] Between 2003 and 2014 FSCO, the legacy regulator, increased the hourly rates every year and indexed it to the CPI. The only exemptions were 2004 and 2013 when rates were not increased and in 2005 when rates were indexed to increases applied by the Ontario Medical Association and not the CPI.

Between 2005 and 2011, the maximum hourly rates in the PSG were increased annually by FSCO, in alignment with the CPI rate. In 2014, the hourly rates in the PSG were once again increased by 0.9% based on the CPI. Since 2014 due to cost and rate reduction efforts, no further increases were made to the PSG. Fees related to "Maximum Payable for Completion of Form" (i.e. completion of OCF 3, 18 and 21) have not been amended since they were established in 2003 as it was not a practice of FSCO to review these annually.

Stakeholder Feedback

HSP and insurer stakeholders have previously provided FSRA with feedback on the maximum hourly rates in the PSG. Some of the feedback FSRA has received and needs to further validate includes the following:

- maximum hourly rates in the PSG have been below market since the PSG was introduced in 2003, and as expenses/inflation increase annually, HSPs are earning less in real dollars.
- increasing rates will support a more healthy and fair insurance system, although a small increase would be insufficient since there has been no increase in nearly 10 years.
- introduction of mandatory annual reviews of the PSG would help ensure rates continue to be appropriate.
- many PSG-related issues center around the inadequacy of the rates that insurers are liable to pay and an increase to the rates may reduce the number of complaints/disputes between insurers and consumers.
- if rates increase, benefit limits will be reached faster, and number of treatments will likely decrease.
    - This issue is more acute for injured persons claiming under the MIG, with a benefit limit of $3,500, as non-catastrophic and catastrophic have much higher benefit limits.

- costs will be added to the system, and this may result in future rate increases. There is already price sensitivity in the sector due to premium increases caused by inflation, high interest rates and automobile thefts etc.

- other jurisdictions that have implemented across the board rate/fee increases for HSPs have seen increases in claims costs due to higher volumes of health services provided.

PSG Options

Option A – PSG: Index the Maximum Hourly Rates

Rationale:

The primary focus of previous stakeholder feedback on the PSG relates to maximum hourly rates and not the maximum payable for completion of forms such as the Disability Certificate/Treatment and Assessment Plan. There is significant HSP stakeholder support for increasing the hourly rates given that these rates impact most of the services that HSPs provide under the PSG (i.e. versus fees charged to complete the OCF 3, 18, which are forms that are less frequently completed.)

Prior to 2014, FSCO regularly reviewed and indexed the PSG's maximum hourly rates in accordance with CPI increases. Given that the maximum hourly rates have not been amended since 2014, consideration should be given to increasing the current maximum hourly rates taking into account the cumulative impact of inflation rate from 2014 to 2023. HSP stakeholders have submitted that according to their calculations, the cumulative increase to the PSG should be in the 20-25% range (indexed to CPI).

Considerations:

- Aligns with past approaches which increased hourly rates based on the CPI.

- PSG hourly rates will become more in-line with market rates.

- Stakeholders report that the current PSG hourly rate only covers about 51% to 84% of fees when compared to what is charged in the market.

- Reduces the amount that consumers may have to cover out of their own pocket.
- Other third-party payor systems in Ontario have also increased healthcare provider fees (i.e. Workplace Safety Insurance Board ("**WSIB**")).
- Consumers may receive less treatment/care due to increased hourly rates (i.e. less care as SABS prescribed limits will remain unchanged).
- The PSG is only available for non- catastrophic/catastrophic consumers, and as these consumers do not currently reach their benefit limits, increases to PSG rates may cause auto premiums to increase. This may conflict with other policy goals relating to minimizing unnecessary rate increases so that rates remain just, reasonable and non-excessive (i.e. consumers may receive less treatment while also paying higher premiums).
- Insurers may object to a large one-time rate increase. On the other hand, HSPs may consider staggered increases as inadequate and the impact negligible.
- Consumers can purchase an optional indexation benefit which indexes benefits to inflation
- Aligns with outcome of consumers receiving the care needed while HSPs are compensated appropriately.

Option B – PSG: Move to Flat Rate Fees

Rationale:

The primary costs of health care services rendered for automobile insurance expenses in the PSG are based on hourly rates, which differs from the unit-based approach for comparable services in other contexts such as the WSIB. Consideration should be given to replacing the use of maximum hourly rates in the PSG with a flat rate or flat fee method of calculation. Flat fees are already used in the PSG for the completion of certain forms (i.e. maximums fees payable for Disability Certificate/Treatments and Assessment Plan).

Considerations:

- Flat rate fees may be appropriate for routine and predictable tasks.
- May result in more certainty of cost for both insurers and consumers.
- Flat fees reduce the complexity of having to calculate the cost of treatment.
- For more complex and unpredictable cases (i.e. catastrophic impairments), flat rate fees may not account for the potential extra time and expertise required.
- Most treatment received by consumers is usually done in 1-hour blocks and the hourly rate already acts like a flat fee.
- Stakeholder feedback does not support moving to flat rate fees over a maximum hourly rate.
- Aligns with outcomes of ensuring consumers receive the care they need and that HSPs are compensated appropriately.

Option C – PSG: Do Not Prescribe Rates

Rationale:

The sector can be given even more autonomy by FSRA not prescribing or setting hourly rates. For example, the PSG could be amended to permit for more of a responsive fee and rate setting approach by introducing the use of terms such as "reasonable" or "at a market rate" (i.e. instead of FSRA setting maximum hourly rates). A rate model that is "reasonable" or "at market" would be negotiated between insurers and HSPs.

Considerations:

- Allows market forces to set rates which focus on care of consumers (i.e. adjust to market conditions).
- Eliminates the need to regularly review the PSG and amend rates.
- Allows insurers/HSPs to negotiate rates that are acceptable to both.
- Consistent with approach taken with other types of insurance (e.g., extended health benefits).
- Stakeholder feedback has indicated that maximum rates found in the PSG that insurers are liable to pay should be based on usual and customary fees.
- May result in an increase in disputes between insurers and HSPs on what constitutes reasonable and/or market rate (i.e. this occurred in the past when HSPs and insurers have had to negotiate rates).
- Given that establishing rates will require negotiation between insurers/HSPs this will inevitably result in an increase in disputes on what constitutes "reasonable" and/or market rate.

- One of the historical reasons that the PSG was introduced was to eliminate disputes between insurers/HSPS that had arisen due to negotiating rates.

- May lead to slower adjustment of claims where there are fee-related disagreements and disputes (i.e. more LAT cases etc.).

- May introduce more variability to the sector as rates may not be consistent and could vary from insurer to insurer (i.e. may require on-site FSRA examinations to monitor variability etc.).

- Aligns with outcome of consumers receiving the care they need while HSPs are compensated appropriately.

Option D – PSG: Status Quo – Maintain Existing Hourly Rates

Rationale:

Any significant increase to PSG rates may result in an increase to auto premiums. Given that premiums have generally been on the rise post pandemic on account of other factors, FSRA is mindful of its mandate to protect public interest and the policy goals of the PSG.

Considerations:

- No additional costs will be added to the auto insurance system which is currently extremely cost sensitive.

- Consumers can obtain services at the PSG rates under the current system. Although HSPs could decide to focus on delivering services to non-automobile insurance customers, there is limited evidence that consumers are not receiving the care that they need.

- Costs are increasing due to inflation and HSPs may have less capacity to care for motor accident victims as they seek work in other more remunerative sectors.
- Could result in even more sizeable increases in the future if decision is made for rates to "catch up" to existing market rates.
- Does not align with outcome of HSPs being compensated appropriately.

PSG Consultation Questions

Determining Rates and Rate Reviews

1. If PSG rates are indexed (Option A), what should they be indexed to and why?

2. If PSG are moved to flat rates (Option B), how should those flat rates be determined and why?

3. Should rate increases (Option A or Option B) be staggered incrementally over a few years, or should it take place at once?

4. Should FSRA review fees regularly, and if so, at what frequency (i.e. annually, biennially etc.)?

5. For Option C how often should insurers/HSPs meet to review/set maximum rates?

Other Considerations

6. Are there other options/considerations related to rates/fees that should be considered for the PSG?

7. Do you have any evidence that consumers are having difficulty obtaining the HSP care they need due to the existing PSG rates?

8. What are the key implementation considerations that must be taken into account for each option (i.e. timing, updates to billing systems, etc.)?

9. How can FSRA help to ensure that any changes to the PSGs are communicated to HSPs, insurers, consumers and other stakeholders?

10. Are there other considerations which have been missed that should be taken into account as part of the PSG review?

Attendant Care Hourly Rate Guideline (ACHRG)

Purpose

Attendant care benefits pay for reasonable and necessary expenses incurred on behalf of the insured person for services provided by a personal support worker ("**PSW**"), a long-term care facility, or for the actual economic loss sustained by family members or friends for providing the care to an injured accident victim (see s.19 (1) of SABS).

The SABS requires that the Assessment of Attendant Care Needs (Form 1), a form approved by FSRA, be used to quantify the dollar amounts payable to a consumer for attendant care benefits. The Form 1 is completed by a nurse or occupational therapist who assesses the number of minutes of attendant care the consumer needs each day for the following three categories of assistance:

Attendant Care Levels	Maximum Hourly Rate
Part 1: Hourly Rate A Level 1 Attendant Care for routine personal care	$14.90
Part 2: Hourly Rate B Level 2 Attendant Care for basic supervisory functions	$14.00
Part 3: Hourly Rate C Level 3 Attendant Care for complex health/care and hygiene functions	$21.11

In Ontario, the auto attendant care benefit model is based on the system in place at the WSIB which utilizes the Activities of Daily Living Scale form, almost identical to the Form 1, as well as similar rates to calculate a monthly allowance. The calculated monthly allowance is used to either allow attendant care services to be purchased from an agency or compensate family members or friends who provide the care (family members must also show an economic loss to be compensated for attendant care). Hourly rates do not vary depending on who provides the care (family members/PSW) instead they are a function of which level of care is provided to the consumer (i.e. both a family member and PSW will receive $14.90/hr for assistance with routine personal care).

The total number of hours expected for each category for each day are multiplied by the maximum hourly rates to calculate a monthly allowance that may be used by the consumer to purchase services or compensate a family member for providing the attendant care. An attendant or agency that provides the services can invoice the consumer/insurer (via the FSRA approved OCF 6) and be paid up to this monthly amount. The maximum monthly benefit payable is $3,000 for a non-catastrophic impairment, and $6,000 per month for a catastrophic impairment. These limits are set out in the SABS.

As of June 1, 2016, the medical, rehabilitation and attendant care for a standard maximum benefit [7] was combined and set at a fixed amount for one accident. For a person whose injury exceeds the benefits set out in the MIG[8], the maximum benefit payable for combined medical, rehabilitation and attendant care benefits is $65,000 for a non-catastrophic impairment and $1,000,000 for a catastrophic impairment. Consumers can purchase optional benefits that provide an additional $130,000 or $1,000,000 of medical, rehabilitation and attendant care benefit coverage for a non-catastrophic impairment, or a catastrophic impairment respectively. The monthly amount payable is subject to additional limitations set out under the SABS (*see Appendix C, “Attendant Care Benefits” for additional details*).

Under the *Act*, FSRA is required to publish certain indexation percentage increases

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[7] The ‘standard’ benefits are available to consumers whose injuries are deemed to be greater than a ‘minor’ injury but not as severe as a ‘catastrophic impairment’, according to the guidelines under SABS.

[8] MIG consumers are entitled to $3,500 in medical and rehabilitation benefits and are not entitled to any attendant care benefits.

annually, for the purposes of the SABS and tort claims and does so in its *Automobile Insurance Indexation Amounts Guidance*. These adjustments ensure the values of consumer benefit payments are maintained in relation to inflation. Some historical hourly and monthly attendant care benefits fall within the scope of the Indexation Guidance (open claims under Bill 164) and thus the annual indexation percentages found in the Indexation Guideline apply to them (1993 SABS).

Historical Indexation

FSCO had reviewed the ACHRG rates annually and they were updated at the discretion of the Superintendent of Financial Services. FSRA does not have a legal obligation to review or increase ACHRG rates.

Between 2010, when the Attendant Care Hourly Rate Guideline was first introduced[9], and 2016, Levels 1 and 3 (for more serious care needs) rates were unchanged. In 2016, they were increased and aligned with the WSIB rates, and the Level 2 rate was also increased to align with Ontario's minimum wage at the time. In 2017, Levels 1 and 3 rates were not changed; the Level 2 rate was increased to $14.[10] Effective October 1, 2024, the minimum wage in Ontario is scheduled to increase to $17.20 from the existing $16.55.

Stakeholder Feedback

Stakeholders have expressed concerns about the ACHRG. Some of the general highlights of the feedback FSRA has received and needs to validate further includes the following:

- rates for all three levels are below market rates and that the increases (indexed to the CPI) should be applied to both existing and new claims to support an insurance system that safeguards adequate services for injured consumers.
- rates must be adjusted to align more closely with the rates paid for personal support in other areas of our healthcare system such as long-term care and homecare as

[9] Prior to 2010, the rates were part of the SABS and changes required regulatory amendments.

[10] The Level 2 rate was increased to $14.00 per hour to reflect Ontario's general minimum wage increases effective January 1, 2018. Level 2 rates historically mirrored minimum wage rates.

previously provided through the LHINs and now Ontario Health Teams (Home and Community Care Support Services).

- increases to the rates may add costs to the system, and this may be included as a rationale for future auto rate increases.
- existing rates are below minimum wage. Consumers may be having difficulty finding attendant care providers that are willing to work below minimum wage, or for anything less than market rates.

ACHRG Options

Option A – ACHRG: Index the Maximum Hourly Rates for All Levels

Rationale:

Levels 1 and 3 hourly rates should be adjusted upward by indexing the increases to the CPI (i.e. 16.7%), given that the last adjustment was in 2018. Level 2 rates have traditionally been tied to Ontario minimum wage increases and would also need to increase from $14 to $17.20. The maximum hourly rates in the ACHRG are used by insurers to calculate the monthly attendant care benefit that is payable. The maximum hourly rates in the ACHRG are not meant to be applied as the maximum payable for attendant care. Any increase to the maximum hourly rate will not coincide with an increase to the maximum monthly attendant care benefit which will remain the same (i.e.$3,000 non-catastrophic or $6,5000 for catastrophic).

Attendant Care Benefits June 2024	FSRA	WSIB	CPI Indexed Rate
Level 1 – routine care	$14.90/hr	$21.70/hr	$17.88/hr
Level 2 – basic supervisory	$14.00/hr	$16.55/hr	$17.20/hr
Level 3 – complex	$21.11/hr	$31.97/hr	$24.63/hr

Even with the proposed rate increases, the hourly attendant care rates for Level 1 and 3 would not be as high as the hourly rates paid by WSIB[11]. However, there are key differences between the auto insurance system and the WSIB that make the comparison of rates for health care providers inappropriate. Many services provided by WSIB are in programs of care where providers treat several consumers at the same time, often in groups, and WSIB can pay above their fee schedule at their discretion since they are a single insurer (unlike the multiple insurers in the auto system).

Additionally, WSIB has a very different mandate than the one in place for auto insurance. WSIB is funded by employers with the primary goal to get injured employees back to work. Contrast this to Ontario's auto insurance system which is funded by consumers who purchase insurance which is focused on the broader restorative purposes of the SABS (i.e. rehabilitation of other aspects of their life besides just return to work).

Considerations:

- Most stakeholder feedback indicates support for aligning ACHRG rates with the CPI.
- New rates for Level 1 and 3 are more in keeping with market rates and align with rates paid in other areas of the healthcare system.
- New rates for Level 2 are consistent with past practice of increasing rates alongside increases in the minimum wage.
- Higher rates may result in consumers being eligible for less attendant care given existing policy limits will not increase.
- Insurers may be critical of any rate increase as increases will be viewed as adding costs to the auto insurance system.

[11] As of June 17, 2024, the average hourly pay for a PSW in Ontario is $28.00 an hour. Although PSWs provide similar services as individuals providing attendant care services under the automobile insurance system, their hourly rates were overseen by the Ministry of Health.

- HSP stakeholders may view the rate increases as inadequate as the increased rates are still below those paid by WSIB.

- Aligns with outcome of consumers receiving the care they need while HSPs are compensated appropriately.

Option B – ACHRG: Index Maximum Hourly Rates for Levels 1 and 3

Rationale:

Level 1 and 3 rates should be adjusted upward by indexing the increases to the CPI (i.e. 16.7%).[12] The existing maximum hourly rate of $14.00 for Level 2 should be maintained.

Level 1 care is significantly more technical than Level 2, however, currently, there is only a $0.90 cent per hour difference between the two levels (Level 1 is $14.90 vs Level 2 is $14). Additionally, Level 3 care is currently paid at a rate higher than Levels 1 and 2, but its rate is arguably out of sync with the skills and time needed to perform the tasks and the complexity of care involved. For example, Level 3 care may be required for a relatively short period of time every day, multiple times a day, but care providers are only compensated based on the time actually spent on the task. Stakeholders note that without increases to the maximum hourly rates, differences between Levels 1 and 3 and market rates may result in injured consumers having difficulty accessing attendant care. This is less of a concern for Level 2 tasks, which are usually provided by family members.

[12] Level 1 and 3 rates were last increased in 2018. To bring these rates up to date to 2023 levels they would need to increase by 16.7% (i.e. 16.7 %=1.9% (2019) + 0.7% (2020) +3.4% (2021) +6.8% (2022) + 3.9% (2023)).

Attendant Care Benefits	Current Maximum Hourly Rate	Indexed Maximum Hourly Rate (16.7%-CPI 2023)	WSIB (2024)
Level 1 – routine care	$14.90/hr	$17.20/hr[13]	$21.70
Level 3 – complex	$21.11/hr	$24.63/hr	$31.97

Considerations:

- Aligns with the rates paid in other areas of the healthcare system.
- Level 2 care is usually provided by family/friends who may not have the same level of skills and training as professional caregivers.
- Addresses HSP stakeholder feedback that Level 1/ 3 rate increases should align with CPI.
- Increases to rates may add costs to the system and cause premiums to rise.
- Higher rates may result in consumers being eligible for less attendant care given existing limits will not increase.
- As all health care costs are going up, it may be perceived as unfair if Level 2 rates continue to remain stagnant.
- Level 2 rates will continue to be lower than the rates paid for personal support in other areas of the healthcare system (i.e. average hourly pay for a PSW in Ontario is $28.00).
- Aligns with outcome of consumers receiving the care they need while HSPs are compensated appropriately.

[13] Effective October 1, 2024, the minimum wage in Ontario is scheduled to increase to $17.20 from the existing $16.55.

Option C – ACHRG: Status Quo – Maintain Current Maximum Hourly Rates

Rationale:

Any significant increase to ACHRG rates may result in an increase to auto premiums. Given that premiums have generally been on the rise post pandemic, FSRA is mindful of its mandate to protect public interest and the policy goals of the ACHRG.

Considerations:

- No further costs will be added to the auto insurance system due to benefits.
- Postponing decision may result in a more significant increase needed in the future to "catch up" if the gap is left to compound.
- May make it more difficult to obtain the attendant care needed, especially for Level 3 (complex care).
- May not address stakeholder concerns that rates are not keeping up with inflation.
- Does not align with outcome of HSPs being compensated appropriately.

ACHRG Consultation Questions

Determining Rates and Rate Reviews

1. How should Level 1 and 3 (Option B) attendant care rates be indexed?

2. Should Level 1 and 3 rate increases (Option B) be staggered incrementally over a few years, or should it take place at once?

3. Should FSRA review the rates of all three Levels regularly, and if so, at what frequency (i.e. annually, biennially etc.)?

Other Considerations

4. Are there other options/considerations related to rates/fees that should be considered for the ACHRG?

5. Do you have any evidence that consumers are having difficulty in obtaining the attendant care they need (Level 1-routine personal care and Level 3-complex health/care)?

6. What are the key implementation considerations that should be taken into account for each option (i.e. timing, updates to billing systems etc.)?

7. How can FSRA help to ensure that any changes to the ACHRGs are communicated to HSPs, insurers, consumers and other stakeholders?

8. Are there other considerations which have been missed that should be taken into account as part of the ACHRG review?

Minor Injury Guideline (MIG)

Background

The MIG was initially issued in 2010 pursuant to s. 268.3 of the *Act*. It is incorporated by reference into the SABS and is binding in accordance with section 268.3 (2.1) of the *Act* and replaced the Pre-Approved Framework (“**PAF**”) for Grade I and II Whiplash Associated Disorders

In September 2010, the concept of “minor injury” was introduced to classify what the health care literature suggests is the most prevalent type of injury sustained in automobile collisions (see s.3 of SABS). Under the SABS, “minor injury” refers to one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury (i.e. minor injury is not considered to meet the tort verbal threshold of “serious and permanent impairment”).

Purpose

The MIG was developed to create a simplified administrative regime, with pre-approved funds and block fees for sets of health services. Consumers whose injuries are predominantly minor, as defined by the SABS, are to be treated under the MIG. The objectives of the MIG are to:

- speed access to rehabilitation for persons who sustain minor injuries in auto accidents;
- improve utilization of health care resources;
- provide certainty around cost/payment for insurers and regulated health professionals; and
- be more inclusive in providing immediate access to treatment without insurer approval for those persons.

The MIG provides consumers with 12 weeks of treatment and $2,200 in benefits, without requiring prior approval from an insurer.[14] Consumers who have completed treatment under the MIG, and who require additional treatment, may submit Treatment and Assessment Plan(s) for approval up to the $3,500 plus HST coverage limit under s.18 (1) of the SABS (i.e. an additional $1,300 after the pre-approval limit is reached). An individual with minor injuries has access to a maximum of $3,500 for medical and rehabilitation benefits, whereas non-catastrophic injuries have access to up to $65,000 in benefits. The majority of consumers with minor injuries do not hit the threshold of $3,500 for medical/rehabilitation benefits.[15]

A fundamental element of the MIG is the Appendix B Fee Schedule (see chart below). For consumers whose injury falls within the minor injury category, there is a predetermined amount of financial coverage that is available for medical and rehabilitation benefits. The MIG Fee Schedule directly affects the amount of compensation health practitioners are paid for the treatment of consumers' injuries.

HSPs able to deliver services within the MIG are limited to those health practitioners, as defined by the SABS (*see Appendix D*), who are authorized to treat the injury and who can deliver the interventions referred to in this Guideline. HSPs may also coordinate or directly supervise the provision of services to the insured person by other appropriate health care providers.

[14] Under the MIG, no pre-approval is required for the first $2,200 of goods/services (i.e. Treatment under the MIG Block 1 (Week 1-4) $775 Block 2 (Week 5-8) $500 Block 3 (Week 9-12) $225 Treatment Total $1,500 Other Initial visit $215 Supplementary goods and services $400 Completion of Minor Injury Discharge Report (OCF-24) $85, Other Total $700) pursuant to Minor Injury Guideline – Superintendent's Guideline No. 02/11 issued in November 2011.

[15] The August 2023 Ontario Health Claims Database HCDB Standard Report indicates that the average MIG claim was $1,258 in 2023 https://a-us.storyblok.com/f/1003207/x/2e067145d6/hcdb-standard-report-2023h1.pdf (see p.34).

Appendix B: Minor Injury Guidelines Fee Schedule

Interventions	Fee
• Initial Visit (1 session)	$215
• Treatment phase (up to 12 weeks post- accident) ○ Block 1 (weeks 1-4) ○ Block 2 (weeks 5-8) ○ Block 3 (weeks 9-12)	 $775 $500 $225
• Health practitioner monitoring (refer to section 8.(c) of the Guideline)	$200
• Completion of Minor Injury Discharge Report (OCF-24) payable once at discharge	$85
• Supplementary goods and services	$400 (aggregate maximum)
• Transfer fee if insured person changes health practitioner	$50
• X-Ray fee	See Appendix C

Stakeholder Feedback

Most stakeholder feedback previously received on the MIG centers on issues outside the scope of this Consultation Paper and do not relate to the MIG fee schedule.

MIG Options

Option A – MIG: Index the Rates in the Fee Schedule[16]

Rationale:

The MIG fee schedule provides a maximum fee payable for initial visit, treatment, monitoring, completion of forms and transfer of file regardless of the HSP providing the care (i.e. different rates are not paid to different HSPs). The fee schedule rates have not increased since the MIG was introduced in 2010 and should be indexed.

Considerations:

- Ensures HSPs are paid at market rates given other third-party payor systems in Ontario have increased healthcare provider fees (i.e. WSIB.).
- Majority of consumers would be impacted by any increase as most injuries fall under the MIG.
- Stakeholder feedback does not indicate that increasing the MIG fee schedule is a pressing issue.
- Increase to the MIG fee schedule would not address broader issues related to the MIG (i.e. cost of providing care for those with more than one injury, classification of MIG/non-MIG).
- The majority of consumers with minor injuries do not hit the threshold of $3,500 for medical/rehabilitation benefits and thus any increase to MIG rates would have only a limited impact on consumers' ability to access treatment.

[16] Appendix C Payment Schedule for X-Rays of the MIG was also reviewed. No changes are recommended to MIG-Appendix C as the existing rates for x-rays are higher than those currently paid by OHIP for comparable services.

- May result in even more efforts being made for consumer injuries to be classified non-catastrophic and/or more LAT disputes, as the MIG benefit limit means that increasing fees for paid to HSPs will result in fewer treatments for some consumers.

- Aligns with outcome of consumers receiving the care they need while HSPs are compensated appropriately.

Option B – MIG: Status Quo – Maintain Fees in Schedule

Rationale:

The MIG sets out the goods and services that will be paid for by the insurer without prior approval if provided by a HSP to an insured person who has sustained a minor injury. The MIG fee structure was intended to cover the services of a variety of HSPs and as a result it may be advisable to maintain the existing fee schedule.

Considerations:

- Rates in fee schedule are generous when compared to other payor systems
    - Initial visit under MIG with a chiropractor is $215 whereas under the WSIB it is only $68.49.
- Fees payable under the schedule are the same regardless of the HSP (i.e. physician receives the same amount that a chiropractor receives).
- Stakeholder feedback indicates that increasing the fee schedule is not a pressing issue.
- Flat fees may have the perception of being too low for certain health care practitioners (i.e. physicians) given the scope of activity they capture.
- The fee for the initial visit is $215. This is inclusive of all assessment and intervention services and includes completion of the Treatment Confirmation Form (OCF-23).
- Does not align with outcome of HSPs being compensated appropriately.

MIG Consultation Questions

Determining Rates and Rate Reviews

1. If MIG rates are indexed (Option A), what should they be indexed to and why?

2. Should rate increases (Option A) be staggered incrementally over a few years, or should it take place at once?

3. Is the existing block fee structure/amounts for pre-approved MIG treatment appropriate? Why or why not?

4. Should FSRA review MIG rates regularly, and if so, at what frequency (i.e. annually, biennially etc.)?

Other Considerations

5. Are there other options/considerations related to rates/fees that should be considered for the MIG?

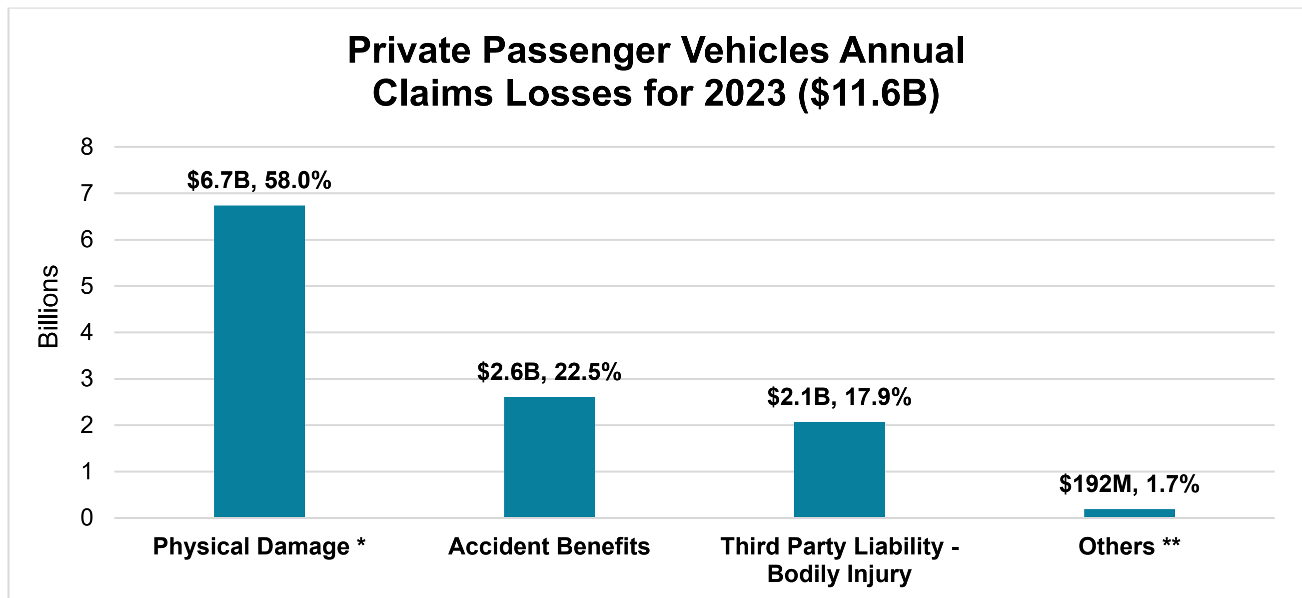
6. Do you have any evidence that consumers are having difficulty obtaining the HSP care they need due to the existing MIG rates?

7. What are the key implementation considerations that must be taken into account for each option (i.e. timing, updates to billing systems, etc.)?

8. How can FSRA help to ensure that any changes to the PSGs are communicated to HSPs, insurers, consumers and other stakeholders?

9. Are there other considerations which have been missed that should be taken into account as part of the MIG review?

Appendix A – Auto Insurance Claim Losses



Auto Insurance claim costs fall into three main categories:

- **Physical Damage:** Insures against a variety of damage such as collisions, vandalism, fire and theft.
- **Accident Benefits:** Provide compensation regardless of fault (i.e. medical/rehabilitation, attendant care, income replacement).
- **Third Party Liability:** Pays for damages to third parties as a result of one's negligence

Appendix B – Listed Health Care Professional/ Providers (PSG)

Note: In the PSG the listed HSPs are called health care professional/providers. Only the listed professional/providers below can provide services under the PSG.

Appendix- Revised Rates and Fees

Health Care Professional/Provider	Maximum Hourly Rate except catastrophic impairments	Maximum Hourly Rate catastrophic impairments*
Chiropractors	$112.81	$135.36
Massage Therapists	$58.19	$89.07
Occupational Therapists	$99.75	$119.92
Physiotherapists	$99.75	$119.92
Podiatrists	$99.75	$119.92
Psychologists and Psychological Associates	$149.61	$179.29
Speech Language Pathologists	$112.22	$134.17
Registered Nurses, Registered Practical Nurses and Nurse Practitioners	$91.43	$109.24
Kinesiologists	$58.19	$89.07
Unregulated Providers		
Case Managers	$58.19	$89.07
Family Counsellors	$58.19	$89.07
Psychometrists	$58.19	$89.07
Rehabilitation Counsellors	$58.19	$89.07

Vocational Counsellors	$58.19	$89.07

*This rate applies to all services rendered on or after September 6, 2014 to an insured person whose impairment is determined to be a catastrophic impairment as defined in the SABS whether such services are rendered before or after such determination is made.

Form	**Maximum Payable for Completion of Form**
Disability Certificate (OCF-3)	$200
Treatment and Assessment Plan (OCF-18)	$200
Automobile Insurance Standards Invoice (OCF- 21)	$0

Appendix C – Attendant Care Benefits

For accidents on or after June 1, 2016	Non-catastrophic claims	Catastrophic claims
Maximum Benefit (Standard Benefit- combined Medical, Rehabilitation and Attendant Care Maximum Limit)	Maximum of $3,000 per month and $65,000 *Medical, rehabilitation and attendant care limits are increased if consumer has purchased the optional coverage of $130,000 or $1,000,000	Maximum of $6,000 per month and $1,000,000 *Medical, rehabilitation and attendant care limits are increased if consumer has purchased the optional coverage of

For accidents on or after June 1, 2016	Non-catastrophic claims	Catastrophic claims
		$1,000,000 (all injuries) &/or $1,000,000 (catastrophic injuries)
Duration	Up to 260 weeks (5 years) if over age 18 at date of loss, otherwise to age 28	Lifetime
Limitations (Set out in regulation not Guideline)	No fees payable to family or friends if there is no income loss. No fees payable unless there is an incurred loss. Rates are fixed based on the date of the accident and do not increase. Attendant Care Benefits are not available if the injuries sustained are classified under the Minor Injury Guideline (MIG).	

Appendix D – Health Practitioners MIG

Note: Under the MIG only the listed health practitioners can provide services.

Statutory Accident Benefits Schedule s. 3 - Definitions

"health practitioner" means, in respect of a particular impairment,

(a) a physician,

(b) a chiropractor, if the impairment is one that a chiropractor is authorized by law to treat,

(c) a dentist, if the impairment is one that a dentist is authorized by law to treat,

(d) an occupational therapist, if the impairment is one that an occupational therapist is authorized by law to treat,

(e) an optometrist, if the impairment is one that an optometrist is authorized by law to treat,

(f) a psychologist, if the impairment is one that a psychologist is authorized by law to treat,

(g) a physiotherapist, if the impairment is one that a physiotherapist is authorized by law to treat,

(h) a registered nurse with an extended certificate of registration, if the impairment is one that the nurse is authorized by law to treat, or

(i) a speech-language pathologist, if the impairment is one that a speech-language pathologist is authorized by law to treat; ("praticien de la santé")