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Lundi 6 mai 2013

Standing Committee on General Government

Automobile insurance review

Comité permanent des affaires gouvernementales

Examen de l'assurance-automobile

Chair: Bas Balkissoon
Clerk: Sylwia Przezdziecki

Président : Bas Balkissoon
Greffière : Sylwia Przezdziecki

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON GENERAL GOVERNMENT

COMITÉ PERMANENT DES AFFAIRES GOUVERNEMENTALES

Monday 6 May 2013

Lundi 6 mai 2013

The committee met at 1404 in room 228.

AUTOMOBILE INSURANCE REVIEW

The Chair (Mr. Bas Balkissoon): We'll call to order the Standing Committee on General Government. We'll just have a small break so we can change the Chair.

Come on over, Rick.

Mr. Rick Bartolucci: Okay. Do we need a motion or anything?

The Chair (Mr. Bas Balkissoon): No.

The Acting Chair (Mr. Rick Bartolucci): Okay, good afternoon, everybody. Let's get started. We have one, two, three, four, five deputants. Just a reminder that they have 10 minutes, and then we each have 10 minutes for questions. We do not have to use our 10 minutes if we don't want to use our 10 minutes.

MR. RON VAN KLEEF

The Acting Chair (Mr. Rick Bartolucci): We'll move forward with our first deputant, which is Ron Van Kleef. Is Ron here? Ron, come forward, please. Welcome to the committee.

Mr. Ron Van Kleef: Thank you.

The Acting Chair (Mr. Rick Bartolucci): Go ahead.

Mr. Ron Van Kleef: Thank you for allowing me to make an oral presentation today. I represent the Hamilton area. I'm the president for Hamilton Cab Co. in Hamilton. Also, we have roughly half of the taxis on our fleet, which represents 200 of the 425 of them that represent Hamilton.

I'm here today because of an extreme situation that has occurred this year in January. Of the 425 taxis in Hamilton, there was no notice of renewal, of non-renewal given. So, as we currently are now, as renewals come up during the course of this year, there are non-renewals happening as we speak. All renewals are different between each party.

I'll give a little history on myself. I've been in this industry since I was a young boy raised in Hamilton. I'm now the president of the company and worked from the ground roots up to where I am now, and that's driving a cab, dispatching, managing and hiring and firing drivers.

We employ 500 people in Hamilton that rely on this business. I also sit on a lot of committees in Hamilton and represent a lot of other areas as well. This is a great concern to us in the area, as the investment of many of the people that have invested for purchasing taxis, employing themselves and employing drivers—they collateralized houses to purchase vehicles or taxi plates and operating a business. Now the informed renewal packages they're getting from the insurances is only one entity, which is a Facility. I know that we're all aware of what that is; Facility is the end-of-the-road type of insurance. A lot of these drivers have been renewed at $16,000 to $20,000 per year, whereas last year they were $5,000 to $6,000.

We get explained that the reason being—a lot of them are coming to me because they sublet the plates through our company or a dispatch company, and they won't be able to afford it, so it's going to put them out of business. A lot of them haven't renewed. Some of them are hanging on to see if something does happen. I've never seen anything like this in the history that I've been in this business. There's always been a solution, but unfortunately there are no insurance companies that are writing our area; they've all pulled out of the market. For what reason? I don't know.

I have a claims history that was given to me for all the vehicles in the area, because we only operate out of Hamilton; we're specific to the insurance in Hamilton only—the jurisdiction—as Toronto is, or Oakville or Brampton or whoever. So, our area, for some reason, and Brampton, has been targeted for non-renewal.

Officially, I haven't got a reason why. I've looked at the claims history and seen that there are a lot of injury reserves put aside, a lot of claims—I'm being told that it's fraudulent claims of benefits of accidents, because none of the vehicle coverage, the actual physical damage of the vehicles, is being submitted. A lot of these drivers pay out-of-pocket not to put it through the insurance. So a lot of the claims that are coming through are either third party or passengers in the vehicle.

One of the other things that they've mentioned too was the insurance company saying that Hamilton has a high risk of low-income people on subsidy, disabled, riders with no personal insurance.

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The way that the no-fault works, as you know, if you're a client in the cab, if the client that's in a vehicle has no insurance, it goes to the driver's insurance. What the insurance company is saying is, there are too many of these types of people with no personal insurance, because

if you or I are in a taxi and get into an accident, our insurance would kick in for coverage for ourselves. But, unfortunately, they're saying that the Hamilton area—and I do believe some parts of Toronto and Brampton are also facing the same challenges.

These are an unknown, why this is happening. All we get is that they've put reserves aside, and when I look at the claims, they're putting reserves aside for three quarters of a million dollars for whatever reason. It's not explained. It's a big situation in the area that we're trying to face and deal with. I don't know what road—I've met with some of my MPPs in the area and discussed the situation, and that's why I'm here today. It was recommended that I come and speak.

I'll give you an example of an operator. We do have a current operator—he's been in the business for 30 years. He owns his own taxi plate. He drives. He's never been in an accident, never put a claim in. I do not understand why that would happen, why he would not be renewed; and he's being told that it's $16,000 to $20,000 when he's the only driver, has a mortgage, has a family. He's one of many others.

I do believe there's a lot of fraudulent cases going on, and it hasn't been defined or actually laid out as to what they are. I know in the current personal industry, you're dealing with, as far as the cutbacks, 10% to 15% on regular people's insurance. I don't understand why other people are punished for a minority group when the majority of the claims are maybe an isolated few. I'm not sure how insurance companies rationalize their reserves. They put them aside and then they say that there are too high claims, and I don't know how they do that. I don't know how they can say that that is allocated for the future.

These are many of the unknowns that we're faced with, and there's nothing we can do at this point except to voice our opinions. It's critical. We've got a lot of people. We might be parking a lot of vehicles on the road. There might be half the fleet parked within the next six months. If we don't do something now, it's going to be a bad situation in our city.

I believe that Brampton and Toronto are also facing some similar challenges, and we need to deal with that ASAP. But I don't understand how insurance companies are not—it's almost like they don't touch it, don't touch the area, and it's very concerning as to how that can be. I think that's where—we don't understand that.

As I said, a lot of lawyers, fraudulent claims are going on, and I think that's the nature the insurance company is facing, that every person is putting in a claim, and it causes a lot of outlay for the insurance companies, probably for lawyers' costs to represent their party, the person that's insured for a claim. It could be a minor claim; it could be anything, but it's cost, and I do know that there is cost to that. As far as that part of it, we're pretty much sitting there in the city not sure how to deal with it. We're hoping that the government steps in and tries to change or find out why this is happening.

The Acting Chair (Mr. Rick Bartolucci): You have two minutes left.

Mr. Ron Van Kleef: Two minutes? Thank you.

I'm not sure how far we go with this or how much the insurance companies will listen. I know that they are governed through our province and I hope that you report back and say that we need to deal with this ASAP, because a lot of people's livelihoods depend on this. When you're dealing with 500 employees, drivers and their families, it's a tough thing to deal with, and I can appreciate that.

I am here today to try to inform you, to give you some information. If there's anything else you would need, I can put it in the format of a letter of all concerns that I can forward off to everybody here at the committee, with relevant information. I think that's about it for now.

The Acting Chair (Mr. Rick Bartolucci): All right. Thank you very much for a very, very insightful presentation.

We'll start off with the Progressive Conservatives, and then we'll move to the NDP and then to the Liberals. In the next round, we'll move to the NDP, the Liberals and then the PCs, all right?

Ms. Laurie Scott: Sure.

The Acting Chair (Mr. Rick Bartolucci): Okay. Laurie?

Ms. Laurie Scott: Okay. Thank you very much for appearing here. I was just trying to get some clarification from my riding, which is Haliburton–Kawartha Lakes–Brock, because we did have a phone call, and I don't know if it was limo services or cab insurance. Do you know if there are limo services that are not being able to get insurance either?

Mr. Ron Van Kleef: No. I have a limousine company as well—separate. I have no issues with that at this present moment, but that could be something down the road that we're facing. I haven't heard anything. Again, we have a good record. If you're operating a good business, then you should be rewarded for operating a good business.

Ms. Laurie Scott: Have you ever phoned the insurance companies or the Insurance Bureau of Canada to ask why?

Mr. Ron Van Kleef: They won't talk to us, because it's your broker. We can only talk to a broker. We can't deal directly with insurance companies.

Ms. Laurie Scott: And did you talk to the broker? Was there any—

Mr. Ron Van Kleef: Yes, and he's facing the same challenges. He just says, "I can't. There's no market." So when there's no market, you go to Facility insurance, and Facility is for the worst. It doesn't matter if it's business or a private person; you have to go to Facility. If you have a bad record on your own personal insurance—if you can't get an insurance company to insure you because of your record—you go to Facility, and it could be a $15,000 premium.

Ms. Laurie Scott: But this is for your company, not individual drivers, right?

Mr. Ron Van Kleef: This is for our taxi driver, yes—the guy who writes the policy for the actual taxi plate.

Ms. Laurie Scott: Okay. You don't know of any other places in the GTA or Hamilton area?

Mr. Ron Van Kleef: Hamilton-specific—nobody is writing Hamilton.

Ms. Laurie Scott: Nobody's writing at all?

Mr. Ron Van Kleef: No.

Ms. Laurie Scott: So what exactly are you doing? Are you going without? Are you paying these bills? Or should I ask that question—

Mr. Ron Van Kleef: They're renewing on a hope—of a six-month policy in the interim—that things will change.

Ms. Laurie Scott: So they're actually signing a six-month—

Mr. Ron Van Kleef: They're signing a six-month renewal based on the hope that there's something being done about this. That's what we're facing here.

Ms. Laurie Scott: I'm glad you came forward today, because I heard some inklings, and then it kind of went quiet, so I didn't know what had happened.

Thanks for bringing it to our attention. We'll follow up. Do you think the ministry is aware?

Mr. Ron Van Kleef: We sent a letter—we had a letter sent to—where is it?

Ms. Laurie Scott: There has been no response, though, from whoever—

Mr. Ron Van Kleef: FSCO—

Ms. Laurie Scott: FSCO, yes.

Mr. Ron Van Kleef: —to fsco.gov.on.ca—to the CEO.

Ms. Laurie Scott: And there has been no response yet?

Mr. Ron Van Kleef: We've had no response.

Ms. Laurie Scott: And how long ago was that, that you sent the letter?

Mr. Ron Van Kleef: That was February 1.

Ms. Laurie Scott: Okay. Do you mind sharing a copy of that with us?

Mr. Ron Van Kleef: Yes, I can do that.

Ms. Laurie Scott: Okay, all right. I'll pass it over to my colleague.

Mr. Todd Smith: Thanks again, Ron. Obviously, this is a huge ordeal for a business owner like yourself, to have to face this kind of a challenge.

When you have heard that fraud may be the root cause of what's driving up the costs for your individual taxi drivers in this case—I'm just curious to get your thoughts on what the government and the NDP have teamed up to do here in our latest budget, which is to drive insurance rates down by 15%. When you talk about the increases that you've talked about, and the inability, I guess, in the first place to get insurance, is this going to solve your problem in any way?

Mr. Ron Van Kleef: Jeez, I can't answer that, I don't think. I just don't understand how you can punish the whole industry for a minority group of people—whoever is operating the vehicles—who do have the claims against them, and for whatever reason—it may be legit; I don't know. I'll give you an example of someone who has driven for 30 years—and the same for everybody here who has personal insurance. Why should everybody else be jacked up for being a good customer and having no claims?

That's why I don't understand how they can shut off the whole industry of Hamilton, let's say, as an example. The ones that are chronic: Yes, you deal with those ones. But the ones that are good: Why are you punishing that person? It's not fair. So I don't understand the insurance companies' whole thinking on that.

I've dealt with insurance for 30 years, so I've been through this. In the late 1980s, I think, we had the same situation, but it got resolved.

The Acting Chair (Mr. Rick Bartolucci): Ron, we're going to ask for a copy of that letter, and Sylvie's going to get it run off for the committee right away. Thanks. Sorry for interrupting, Todd.

Mr. Todd Smith: No problem.

How many claims would there be in a year for your taxi company?

Mr. Ron Van Kleef: I have the claims history here with me, but it doesn't explain—and that's the problem with it. It's very vague. It's just numbers at the bottom, saying "loss ratios, reserves put aside." There are no names, no nothing. It's just more of a general list, an Excel spreadsheet-type thing, but it doesn't really explain what they are. Most of them are third party claims for benefits and disability claims.

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That's why I was trying to explain that there's no physical of the vehicle. There's no payout at all on a lot of these claims. It's more of the benefits and the ongoing forecasts—the reserves that they put aside. The insurance company puts aside a reserve, so if you get in an accident, they're saying, "Okay, $250,000 is put aside for that person," hoping that will take care of it in the next five to 10 years, but what they do is, they have two or three or four of those claims, and they'll keep them as a thing against the actual record of your claims history. That's why they're saying there's a risk. Hamilton seems to have a higher risk than everybody else. I don't know what the explanation is.

Mr. Todd Smith: I represent a riding which covers the Belleville area. There are a number of cab companies in the Belleville area, and I can tell you that some of the companies don't hire drivers that are under the age of 25 because of the high costs to insure those drivers. Would that have any impact on the drivers that you have working for you, or is it just an across-the-board—it doesn't matter what your driving record is; you're not getting insurance.

Mr. Ron Van Kleef: No, 25 is the limit for insurance. The same insurance companies that insure Belleville insure Kingston and Ottawa. Those companies will insure those other markets, but Hamilton? No, and that's why it's disturbing. It's just like, how can you just pick Hamilton and say "no," when the same insurance company—I have a letter here from Aviva, their letter to you guys in the government, April 4, 2013, trying to change

the industry—their industry, the insurance industry. That's something I could add as well, on the record.

Mr. Todd Smith: But you did mention fraud, and fraud has come up in your conversations with insurers.

Mr. Ron Van Kleef: Yes.

Mr. Todd Smith: Do you not think it would make more sense, instead of putting out an across-the-board 15% rate reduction, then, to try and root out the cause when it comes to fraud?

Mr. Ron Van Kleef: I don't know.

Mr. Todd Smith: If that's what's responsible for getting you in the predicament you're in, if it's fraud, wouldn't it make more sense to follow the guidelines of the anti-fraud task force and try and—

Mr. Ron Van Kleef: It should. I don't know how much—and it doesn't analyze here. It doesn't separate what fraud is—the portion of the liability claims that are third party for injury. A lot of them are customers, too; there are a lot of fraudulent claims that come through our ridership. It's at a point now where, "Okay, you can't get in the cab unless you've got personal insurance," because that's how it resorts. If you're in an accident and you're in the cab—say you went out on a Friday night or something and you need to take a cab home. If I got in an accident, my personal would take care of me, whereas they're saying that Hamilton has a high ratio of welfare, social assistance, disabled, low-income, ODSP-type customers in that area, and it's almost like it's a monopoly of insurance companies getting together and saying, "Don't write in Hamilton." That's the perception I'm getting and the feedback I'm getting.

Mr. Todd Smith: Because one of the things we've heard about during testimony here in front of this committee, is that if they bring in this across-the-board 15% reduction in auto insurance rates, it's actually going to drive competitors out of the province and it's going to make it more difficult for companies like yours to acquire auto insurance.

Back to what we're talking about here, this proposal by the government and the NDP for across-the-board rate decreases for auto insurance: It's going to have a negative impact on small businesses like yours. I understand the situation that you're in; obviously, you're scratching your head trying to figure out what to do next, but coming here is a good first step, and thanks for coming in here. Thanks, Chair.

The Acting Chair (Mr. Rick Bartolucci): Thanks very much, Todd. All right. We're going to move to the NDP now. Ron, representing the NDP is Jagmeet Singh.

Mr. Ron Van Kleef: Okay.

The Chair (Mr. Rick Bartolucci): Jagmeet?

Mr. Jagmeet Singh: Thank you so much. Thank you so much for being here, Mr. Van Kleef. Just to touch on a couple of points and just perhaps to clarify some of the things that Mr. Smith, my colleague over here from the PCs, was indicating: One of the things that I think you might find—I want to hear your response to this. The IBC's facts and figures on this and the industry figures on this are that, across the province of Ontario, 80% of people with personal automobile insurance never make a claim in their lives. The vast majority of people never actually make a claim, and there's only 20% of people—the average in the province—who actually make a claim in the first place.

Knowing that the vast majority of people never make a claim ever, that only 20% of people actually make a claim—and, so far, the only numbers that we have in terms of fraud are based on the Auditor General's report. He represents the entire province and does great work in auditing. He attributes fraud to be about 10% to 15% of the total cost.

So if 20% of people actually make a claim, and fraud is only 10% to 15%—you indicated that it's a minority. The numbers show that it's a very, very small, small minority of people. Does it make any sense to you, then, given the fact that the majority of people don't make the claims and that the fraud is a small percentage, that that's being used as an excuse for why rates are—they're not covering you in Hamilton?

Mr. Ron Van Kleef: I would say so, because when you're looking at personal insurance, it's different than a transport carrier like ourselves, as a commercial vehicle, because we're carrying people.

Mr. Jagmeet Singh: Exactly.

Mr. Ron Van Kleef: So you can't compare that. It's a different—I guess it's like apples and oranges. You've got different situations there, and you're dealing with reserves and a lot of the—they put the reserves aside for the industry, and they usually go high.

Mr. Jagmeet Singh: Okay. And just talking about that, actually, one of the things that's getting mixed up a bit is that there's personal automobile insurance—not for a commercial purpose—and then there's commercial insurance. Those two things are obviously different. Your company deals with the commercial side. Is that right?

Mr. Ron Van Kleef: Correct.

Mr. Jagmeet Singh: So just to understand the situation and how dire it is in Hamilton, what I understand is that the exact same person, the same driver, with the same claims record and the same driving record, was being charged something around $5,000 to $7,000 previously, and then in one year's time, that same person is now being asked to renew for $16,000, $17,000, almost $20,000. Is that the situation?

Mr. Ron Van Kleef: Yes.

Mr. Jagmeet Singh: So it's not a case that there has been an increase in terms of what you know as the president of your company, that over one year's time there has been a significant increase in claims or your drivers all of a sudden have become dangerous drivers. That hasn't happened in one year's time, has it?

Mr. Ron Van Kleef: No, and that's why I looked at the history of these claims that was presented to me from the insurance broker. It's all of Hamilton. It's a combination of the last two or three years.

Mr. Jagmeet Singh: And it doesn't show that there's this big spike or this big increase in terms of the claims in your industry?

Mr. Ron Van Kleef: No. Also, there's an at-fault chart. The at-fault chart says how many accidents are at fault or not at fault, and the majority are not at fault.

Mr. Jagmeet Singh: The majority of your cars—

Mr. Ron Van Kleef: Yes, they're not at fault. There's the odd one or two that are the ones that are creating concern—the reserves.

Mr. Jagmeet Singh: So not only is there not an increase in terms of the claims, from what you're seeing in your reports, but in fact there's not even any increase in at-faults in terms of your drivers?

Mr. Ron Van Kleef: No.

Mr. Jagmeet Singh: Okay. And just to kind of understand what this means to an actual employee, one of your employees—you have 500 employees in your particular company. Is that correct?

Mr. Ron Van Kleef: Yes, at our company, and probably the same in the other one.

Mr. Jagmeet Singh: In total, how many drivers do you think there are—

Mr. Ron Van Kleef: Some 800 to 1,000.

Mr. Jagmeet Singh: Some 800 to 1,000.

Mr. Ron Van Kleef: Part-time, full-time—mostly full-time, because there are day and night drivers, so there are two shifts.

Mr. Jagmeet Singh: Sure. So let's talk about a full-time driver. If a full-time driver has to renew their insurance at somewhere between $15,000 and $20,000, what does that mean in terms of their—I mean, we all know that's a high amount. That must be, obviously, a serious issue.

Mr. Ron Van Kleef: Yeah.

Mr. Jagmeet Singh: Paint the picture for us: How serious is that? I mean, would that person be able to continue to be a taxi driver?

Mr. Ron Van Kleef: Probably not. When you're looking at the insurance cost jumping from $5,000 to $20,000, it's a significant amount of money a year—and not only that but the fuel costs, the repair costs. So when you're looking at it, they're saying, "We can't afford to operate." When they're taking food out of their mouth to put it in the insurance, they're not able to survive, so they just stop.

Mr. Jagmeet Singh: They just stop?

Mr. Ron Van Kleef: Yes. They can't do it.

Mr. Jagmeet Singh: They just can't do it. So in terms of your opinion, if nothing changes and if things continue to go in the direction that they're headed right now, where the rates are so high, what do you predict in terms of the 800 to 1,000 taxi drivers in Hamilton? What's going to happen to them?

Mr. Ron Van Kleef: Each driver will have to pay a little bit more money.

Mr. Jagmeet Singh: And do you think there will be a drop in terms of how many taxi drivers are actually going to operate in Hamilton?

Mr. Ron Van Kleef: Yes, half.

Mr. Jagmeet Singh: You think half of them won't—

Mr. Ron Van Kleef: We won't have drivers.

Mr. Jagmeet Singh: Okay. What's the impact on that in terms of Hamilton in general? What would the impact be, in your opinion, in terms of keeping—

Mr. Ron Van Kleef: Some 400 or 500.

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Mr. Jagmeet Singh: Okay. And then in terms of the actual city itself, I'm assuming that's going to be a big problem: being able to find a taxi, being able to get around in the city. Do you have any sense of how much of an impact that would have on the city itself, not having half of the taxi drivers basically being able to provide those services?

Mr. Ron Van Kleef: And you'd be servicing 50% of your customers. You wouldn't be able to do it, because you need the vehicles—a lot of seniors, a lot of hospitals. We transport the disabled community a lot as well. So you're looking at all aspects of the citizens of Hamilton. It's going to affect everybody. And the other thing, too: drinking and driving. You won't be able to get a cab at night. People are going to start driving their cars—Burlington has a tough time as well.

Mr. Jagmeet Singh: That's a good point.

Mr. Ron Van Kleef: The people will be driving home who can't get a cab. So now you're going to be fighting the "Well, I couldn't get a cab, so that's why I drove home drunk."

Mr. Jagmeet Singh: That's a good point.

Mr. Ron Van Kleef: And I know this because I see—we know what goes on at night. Friday or Saturday nights are one of the busiest nights. When you're trying to promote people to take a taxi home, you're now cutting yourself short there because you've only got half the vehicles anymore, and you may be lucky to get one.

Mr. Jagmeet Singh: Okay. One of the other things you brought up—and I had something that I've actually been raising. In some of the areas where insurance companies are claiming or they're trying to say or they're suggesting that there are high claims costs, there are also, they're indicating, people who are—for whatever the reasons may be, but either they're on disability or they're low income or they're on social assistance. There seems to be a suggestion that those people cost them more, even though they're not necessarily a dangerous driver and anything inherently wrong with them. They just happen to be less well off, and that has been something that has come up to you. How does that come up?

Mr. Ron Van Kleef: It's being told to me through the industry. Brokers have approached me, saying that the reason is because of the high percentage of risk. Insurance companies don't want to risk.

Mr. Jagmeet Singh: So the risk isn't necessarily that they're dangerous as in risky drivers, but they're risky in the sense that they're just not well off and they're poor.

Mr. Ron Van Kleef: It's a risky investment.

Mr. Jagmeet Singh: Interesting.

Mr. Ron Van Kleef: Yes. That's what it's about. It's a risky investment, so why invest there?

Mr. Jagmeet Singh: How would you feel knowing, in terms of the policies, that insurance companies aren't

allowed to base someone's insurance rates based on their income level? That's actually something that's prohibited. You're not allowed to use someone's income level to set their insurance rates. To me, it sounds like they're doing the same thing, basically, in a roundabout way.

Mr. Ron Van Kleef: I would think so.

The Acting Chair (Mr. Rick Bartolucci): Less than two minutes, Jagmeet.

Mr. Jagmeet Singh: Okay. So far, this is impacting taxi drivers specifically, and you think that this might happen to limousine drivers as well, but you don't know yet.

Mr. Ron Van Kleef: I haven't heard anything yet. But that's about it; it could. It's transportation, right?

Mr. Jagmeet Singh: And I know something similar has happened to London as well. London taxi drivers are also, almost all of them, put into Facility as well. Are you familiar with that or aware of that?

Mr. Ron Van Kleef: No.

Mr. Jagmeet Singh: Okay. And so far in Brampton and in the GTA, has there been any impact, as far as you know, with the commercial vehicle insurance for those taxi drivers?

Mr. Ron Van Kleef: I don't know of any there.

Mr. Jagmeet Singh: Okay.

Mr. Ron Van Kleef: I know Brampton has its own situation going there.

Mr. Jagmeet Singh: Okay. I guess maybe a couple of seconds left. Anything else you'd like to add in your couple of seconds?

Mr. Ron Van Kleef: No. I'm good.

Mr. Jagmeet Singh: Okay. Thank you so much.

The Acting Chair (Mr. Rick Bartolucci): Thank you. We'll go over to the Liberals. Any questions?

Mr. Bas Balkissoon: Thank you, Mr. Chair. I have a couple, and then my colleague here has a couple. Thank you for being here. I just have a couple of questions because at the beginning of your presentation, I had trouble understanding, because there's noise outside here. You said you actually own these cabs, or are you operating the dispatching system?

Mr. Ron Van Kleef: Our cab company does the dispatching, so it's the brokerage. So when you call, we're the ones who facilitate the call, put it in dispatch mode and send it to the vehicle. All the taxis in Hamilton—the 425 taxis in Hamilton—are owned by a combination of us as shareholders, as well as many private people who own their own. So they may operate their own cab, one person; two cars, they may operate as well, or they own 10, or maybe 30. It's a combination of a lot of types of operators.

Mr. Bas Balkissoon: Okay. You indicated that a lot of the drivers, when they do have an accident, take care of the vehicle repairs themselves, and it's not given back to the insurance company. But is there a trail of a record, say with a police report? A reporting centre report? With these people claiming, is there anybody doing a correlation that they're making a claim of a real accident that took place?

Mr. Ron Van Kleef: By law, they're supposed to. I don't know, because we don't directly deal—the operator will deal with the insurance company directly. We're not like a middleman or a front-runner on the policy itself. I made a presentation to a couple of insurance companies and they're looking at it now: that we would govern the insurance under our umbrella as a company. But yeah, they should be putting a claim in, but there's no physical damage to their own vehicle because there's a third party involved, which could be a person or another passenger or a driver involved. You always report the claim.

Mr. Bas Balkissoon: But this insurance company that's carrying most of the policies—I'm hoping through the broker. Has the broker tried to work with the insurance company and get any kind of statistical data as to where these claims are, who the claims are? Was it a legit accident?

Mr. Ron Van Kleef: No.

Mr. Bas Balkissoon: Nothing of the sort?

Mr. Ron Van Kleef: We don't have any communication with the insurance company. We provide commercial general liability for our customer over and above the $2 million auto, as per the insurance requirements of the bylaw. So we provide company insurance over and above; if there are any claims that go above that, it's a commercial—CGL, it's called.

Mr. Bas Balkissoon: Okay. My colleague here.

Mr. Vic Dhillon: Thank you very much for appearing today. I just want to clarify: Are all drivers being forced to go on Facility? Is it all of them?

Mr. Ron Van Kleef: All of them.

Mr. Vic Dhillon: Everyone has to pay $15,000 to $20,000?

Mr. Ron Van Kleef: All of them.

Mr. Vic Dhillon: Which is really unfair. Myself and some of my colleagues have started to ask questions. Insurance is regulated provincially. Taxis are licensed through the city, and the city has an obligation to taxicab owners/drivers, and the drivers have an obligation to the city. Taxis are a very important service, as you mentioned, for WSIB clients, for patients who have to go to the hospital, and many, many other segments of the population who rely on this service for their daily living.

Have you brought this to the attention of the city? I'm not deflecting the fault to the city, but they are a major stakeholder with respect to this whole issue. Is the city aware of what's happening? Because they're the ones that have the responsibility, just like transit, of ensuring that there is another option for people who don't have their own vehicles or are unable to use their own vehicles.

Mr. Ron Van Kleef: The city of Hamilton actually voted at a council meeting; it's public record. They sent a letter to the province regarding the concerns and are supportive of—

Mr. Vic Dhillon: Do you know when that was?

Mr. Ron Van Kleef: It might have been a couple of months ago? Maybe a month and a half, two months ago? It's on public record; the city of Hamilton voted unani-

mously to put a support letter of concern to the province and helping understand what's happening in Hamilton.

Mr. Vic Dhillon: Were you part of the delegation?

Mr. Ron Van Kleef: No. It was the actual city council. The city of Hamilton actually forwarded that letter to the province regarding the situation that we're dealing with.

Mr. Vic Dhillon: Yeah, okay. I just want to say, in the end, I do have a long history and relationship with the taxicab and limo industry. I'll tell you straight up: This is totally unacceptable, especially hearing that just because people who may not have the means, as some people living in another area—I feel this may be just crossing the discrimination line. We plan to look into this and see what solutions we can come up with. So thank you very much for appearing before the committee.

Mr. Ron Van Kleef: Thanks.

The Acting Chair (Mr. Rick Bartolucci): Ron, thanks very much for your presentation and for asking the questions and, in a very, very real way, providing us some information that some of us didn't know before. It will be very, very useful. Thank you so much.

Mr. Ron Van Kleef: Thank you very much.

MR. BICK DHALIWAL
MR. JASMINDER SINGH

The Acting Chair (Mr. Rick Bartolucci): Our next deputants will be Jasminder Singh and Bick Dhaliwal. Both are going to come to the mike, but I think Bick is going to be doing the speaking.

So, Jasminder and Bick, welcome, and we look forward to your presentations.

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Mr. Bick Dhaliwal: Thank you, and good afternoon to all the committee members and the Chair.

Again, I'm going to say hello and good afternoon to the committee members, the Chairperson and all the dignitaries. My name is Bick Dhaliwal. First of all, I really appreciate the opportunity to speak before you on behalf of Brampton and west-end residents.

As we all know, the auto industry has become a focal issue for all drivers, regardless of which industry they belong to, but mainly the taxi drivers are being penalized much more than other sector industries.

The Liberal government has recently promised to reduce auto insurance premiums by 15%. We believe this is a step in the right direction, but we also feel that it is too little and too late.

Of all the provinces, Ontario is by far the most costly place to buy car insurance. A recent study by the Fraser Institute found that Ontarians pay, on average, double the premium annually for auto insurance compared to Quebeckers and other provinces.

Committee members and Chairperson, there are a few communities in Ontario, such as Brampton, London and Hamilton, that have been targeted with unfair insurance hikes compared to other municipalities. The insurance companies have discriminately raised their premiums by postal codes. That, we feel, is equivalent to racial profiling. That is not only an unethical practice by any standards but also discriminatory and a very impractical approach.

As I became aware of such facts, I conducted some research that indicated that 80% of people have clean records and never make a claim, which leaves us with 20% of the population that file claims. Out of that 20% of the population, let's suppose that 10% of them are legitimate claimants, so that leaves us with 10% or under whom we can consider as fraudulent claimants, yet those 90% of people—decent, hard-working individuals who work day and night to support their families—are being penalized for the actions of a few. This shows that this system is not working properly. This is not a fair system and we should be holding those people accountable, not the 90% of the people who live their lives honestly and in a hard-working manner.

I believe the system has to be analyzed and it has to be changed. The insurance industry is a private venture that does not share its profits yet seek the shelter of government for their unprotected and loose ends. The insurance industry should not hold 90% of the people as scapegoats.

I feel that the Financial Services Commission of Ontario has to take measurable steps to address these issues with the insurance industry. I urge the commission not to act as a rubber stamp in favour of insurance companies, but for the public which has voted them into power.

Committee members and the Chairperson, many of the west-end residents I'm speaking on behalf of today are taxi drivers who make their ends meet very tightly due to high insurance premiums. As you may be aware, taxi drivers in London and Hamilton are paying up to $20,000 insurance premiums. That is up from $7,000 over a year. How would you expect those families to survive? What is the rationale for doubling the premium? There is no rationale. The insurance companies are on the loose and there's no one seemingly who would like to handle them.

Taxi drivers in Peel and the west end also feel they will be suffering the same consequences soon. Please, I urge all the political parties to show their concern, sympathy and empathy for the hard-working taxi drivers by lowering their insurance premiums.

Since 2006 to the present, the provincial government has dramatically trimmed accident benefits, and insurance premiums have continued to skyrocket. Insurance companies may rightly blame fraudulent claims as justification for higher premiums, but as a business entity, they should regard this as theft and not penalize the 90% of the decent customers.

There was some suggestion that from the fraud reduction, the insurance companies would be able to reduce premiums. I would like to end my speech by asking the panel: Do you really expect the insurance companies to voluntarily pass savings made from fraud reduction right along to the consumers? It's like the oil companies passing along savings when the market price for crude falls. I think not. That's not going to happen.

Therefore, let's all be rational and be logical. We should hold insurance companies accountable for their actions for raising unnecessary premiums. Thank you for your time.

The Acting Chair (Mr. Rick Bartolucci): Bick, thank you very much for your presentation. We're going to ask Jagmeet to start his 10 minutes. Thank you, Jasminder and Bick. Jagmeet, go ahead.

Mr. Jagmeet Singh: Thank you so much for being here today, and thank you for your presentation. I just want to start off with general questions about Brampton and then move on to the taxi industry. You indicated that it seems to you like there are certain areas that are being discriminated against, because the rates are higher. Why do you feel like it's discrimination?

Mr. Bick Dhaliwal: Well, clearly we have evidence. Postal codes in Brampton are being targeted. I have friends, taxi drivers, and when they call insurance brokers from all different companies, when that postal code was given to them, there was a much higher quoted premium. Then, if the same person—same status, age, record—called from another postal code, their premium was much lower. Even maybe half a block away, if they moved to Caledon, it's 30% lower than Brampton. Totally, I consider this to be unjust.

Mr. Jagmeet Singh: Unjust. Just as an everyday citizen and a taxi driver, the idea to you, doesn't it strike you—I mean, it strikes me as unfair, but just tell me your reaction: the idea that you, the same driver, live in Brampton and, like you said, if you move a couple a couple of blocks away into Caledon, because Brampton and Caledon are touching—the fact that if you move into Caledon, just a little bit away from where you live, a couple of kilometres away, all of a sudden you will see your rates go down by a lot. Does that make sense to you as a system? Does that seem fair to you?

Mr. Bick Dhaliwal: Like I said, it's totally unfair. What that is causing is people to move out of Brampton. This is sort of a pressure migration happening. What that will lead to is that there will be lesser services in the area where we live. It's the same problem that Hamilton and London are facing. The Brampton residents and ill people and people who cannot service themselves will have a problem.

Mr. Jagmeet Singh: Okay. So let's actually talk a little bit about the taxi industry specifically. We've seen and we've heard today from Hamilton—we know that the rates have gone up for taxi drivers in Hamilton, skyrocketed, and are extremely high. Basically, a lot of people are not going to be able to continue to be taxi drivers. Also, I've heard some stories that it's happening in London as well, that the rates have gone up. Have the rates gone up now in Brampton significantly, or is it a concern that they might start to increase?

Mr. Bick Dhaliwal: Well, it's a concern for all the taxi drivers, because they see that it can happen in London and Hamilton, and there's a fear among the community. It's a great fear that it may come to them. We're trying to take proactive measures, and that's why we're here today: to let the government know that that is our concern.

Mr. Jagmeet Singh: Okay. Just talking about—I mean, the word gets tossed around a lot; people talk about fraud a lot. As a party, we believe that of course we want to get rid of any fraudulent activity. One of the things that you touched on today a little bit, and it has always struck me—I'm concerned about what the consumer thinks about this. In any other industry, if you are a shop owner and you're experiencing a lot of losses in your shop, if you're a Walmart or a big store like this, I would never imagine ever that a Walmart or a Home Depot or a local store would say, "We're having a lot of shoplifting. Let's go to the government and ask the government to fix this problem for us. Let's ask the government to get rid of the shoplifting because we're losing too much money."

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I never understood how the insurance companies had the gall to suggest that someone else has to fix the problem, that they couldn't hire loss prevention people themselves, that they couldn't have investigators do it themselves. They're a multi-billion-dollar industry; why don't they just deal with the issues themselves? I don't understand. As a taxi driver and just as a Brampton resident, what's your response to that?

Mr. Bick Dhaliwal: Well, that's so rightly said. Again, like I mentioned in my presentation, the insurance companies are a private venture, and they're profitable companies. They should be able to guard their loose ends and they should be able to curb any fraudulent activities. That is their job. They should not come to the shelter of the government if they have any leaks in their insurance system. I don't think they can hold the whole public or the government responsible for that. If a store owner, say, has a theft, their employees are stealing something, it is the store owner's obligation and his duty to protect his business. They don't go out to ask the public for help or increase the value of the merchandise.

Mr. Jagmeet Singh: Talking again about the claims: That's something that's very readily available in the Auditor General's report, talking about the number of people that make a claim and the percentage of fraud. A number that used to get tossed around was $1 billion. Today, I see, Aviva has increased that to $1.6 billion annually; that's what they're saying that fraud is. Basically, the overall industry is $9 billion to $10 billion. That's their cost. Either way you look at it, whether it's $1 billion or $1.6 billion, fraud is just one small portion of the costs. Just as an average citizen, have you seen—the industry is saving about $2 billion annually because our benefits have gone down, so the amount of money that the insurance companies pay out to us has gone down by a lot. And that's gone down for over two years, our stats are saying, and IBC agrees with this; the insurance bureau says, "Yes, we agree. We're saving about $2 billion annually. We're not paying out that much money." But people's rates haven't gone down.

As a consumer, do you feel skeptical, or are you doubtful that if we do anything else to reduce their costs,

that's actually going to result in savings for us? If we've already seen the insurance companies save so much money but they haven't brought our rates down—I mean, as a consumer, what's your opinion? Are you skeptical that if we do any further reductions for them, they'll actually pass on those savings to us?

Mr. Bick Dhaliwal: Well, definitely, I'm very skeptical about that, because we feel that regardless of how much reduction in fraud or how much money the insurance company is saving, it is not coming to the pockets of the consumers at all. It will go into their deep pockets and they will use that to lobby the government to make laws in their benefit, so as consumers we will still be losing. It's a vicious circle, but I think the consumers will be always penalized for that and I have no trust in it right now.

Mr. Jagmeet Singh: Okay. And just in closing—

The Chair (Mr. Rick Bartolucci): Two minutes.

Mr. Jagmeet Singh: Two minutes? And just in closing, I guess, if you could talk about maybe a couple of questions: What do you think needs to happen on the commercial side for taxi drivers? I guess this also applies to other commercial drivers, but right now, it looks like taxi drivers are the ones that might be impacted sooner. There might be an impact down the road for truck drivers and other commercial vehicles. But what needs to be done, in your opinion, to make sure that people can continue to be taxi drivers and limousine drivers so that the industry isn't hard hit? What can we do to make sure that—because right now, the prospects look pretty bad. What needs to be done?

Mr. Bick Dhaliwal: Well, I believe, as everyone on the committee knows, that driving a taxi is not a lazy job. It's a long-hour job, and the remuneration is not as much as you would expect. To make ends meet is really hard, with the high gas prices and insurance escalating every time. Basically, what I feel is, as the insurance prices keep going up, they'll be forcefully driven out of the industry. I don't know if the city has any backup plan or if the government has any backup plan in order to service the public, but I believe, with the escalating insurance premiums each year, the taxi industry is in danger.

Mr. Jagmeet Singh: Okay. Thank you.

The Chair (Mr. Rick Bartolucci): Thank you very much. We'll move over to the Liberals. Bas?

Mr. Bas Balkissoon: Thank you very much for being here.

Mr. Bick Dhaliwal: Thank you.

Mr. Bas Balkissoon: You opened by providing us a lot of statistics about 80% of the drivers out there never have a claim, 20% have a claim, and maybe 50% of those are problematic or claims that are fraudulent. But you do believe there are people out there who are making claims. Am I correct?

Mr. Bick Dhaliwal: Well, of course, yes. That's part of the nature of the industry.

Mr. Bas Balkissoon: Okay. Do you believe those claims are very significant in the years prior to 2010?

Mr. Bick Dhaliwal: Well, significant in which way? If it is cost-wise or—

Mr. Bas Balkissoon: Cost-wise; the value of the claims that were being made against the general insurance industry.

Mr. Bick Dhaliwal: Well, it could be considered significant, because I don't have the stats before me to look at for each claimant. But I still believe the number of drivers and cars—comparatively, if you match and if you try to compare it, I still believe it's not that significant, according to the premiums that they're charging.

Mr. Bas Balkissoon: Okay, but let me ask you a simple question, then. If there is a claim against the industry, where should that claim cost fall on? Should it be picked up by the industry, or should it be picked up by somebody else?

Mr. Bick Dhaliwal: Of course it should be picked up by the insurance company, because they are in the business to provide protection. That's what they get the premiums for.

Mr. Bas Balkissoon: Okay.

Mr. Bick Dhaliwal: That is part of their business, the nature of their business.

Mr. Bas Balkissoon: And do you realize that automobile insurance is mandatory in Ontario?

Mr. Bick Dhaliwal: I understand it's mandatory.

Mr. Bas Balkissoon: And it doesn't compare to my friend's example of Walmart?

Mr. Bick Dhaliwal: Well, you know, again, why it's mandatory is because the insurance companies made sure that it became mandatory, because that's how they generate revenues.

Mr. Bas Balkissoon: The Ontario government makes it mandatory—

Mr. Bick Dhaliwal: Yes.

Mr. Bas Balkissoon: —and this is why the government is involved with the industry. It's nowhere comparable to my friend's example that if Walmart has a lot of stolen goods, they would come to the government for help. We don't control Walmart.

Mr. Bick Dhaliwal: I understand that, but—

Mr. Bas Balkissoon: We don't make Walmart mandatory in any way or form.

Mr. Mike Colle: Oh, God forbid.

Mr. Bas Balkissoon: And God forbid, my friend says.

Mr. Bick Dhaliwal: If I could answer your question: Basically, like I said in the beginning, who is controlling who? According to the report I have in front of me, I have facts that support basically the insurance companies are controlling FSCO, the government body, by lobbying. In your suggestion, insurance is not a private entity like Walmart, but yet they have the power to control government legislation that would support in their favour.

Mr. Bas Balkissoon: You're just speculating that, because there's no proof to it. Do you have proof?

Mr. Bick Dhaliwal: Well, I have the reports that I printed—

Mr. Bas Balkissoon: No, if you have proof, I'd like to have it. But if you're looking at something that is speculative, I'm not interested.

I'll carry on here. So you do believe that the claims that are being made against the industry—those expenses should remain within the industry. If the industry believes, and those that are involved in it, like FSCO, have enough evidence that it's fraud, do you have an idea how the government should work with the industry to deal with the fraud?

Mr. Bick Dhaliwal: Well, if it's fraud, there should be an act. There's a government agency that we use in every other sector that—if there's a fraud, there should be repercussions, legal repercussions. Their licence should be taken away. There should be legal implications, not an increase in the rates of the 90% of the people who have nothing to do with it. If somebody commits a crime, they should be held responsible, not the rest of the public.

Mr. Bas Balkissoon: But if we don't have enough evidence to fine them, what else would you suggest the government do?

Mr. Bick Dhaliwal: If the insurance company doesn't have enough evidence to do it, then who's going to provide them the evidence? It's their job to hire people, private investigators, or conduct their own—design a plan so they can do it. I mean, that's what they've got premiums for.

Mr. Bas Balkissoon: Okay. If you disagree with the current model of insurance companies setting their rates, which is your concern that Brampton is high, and London and Hamilton—and I can tell you that my own neighbourhood of Scarborough is also high—should the people in Thunder Bay or North Bay be paying for the fact that the folks in your area and in my area and in Hamilton and in London have more claims than the people in North Bay?

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Mr. Bick Dhaliwal: No. They should be on an individual basis. Who—

Mr. Bas Balkissoon: Sorry, it should be what?

Mr. Bick Dhaliwal: The insurance premiums should be based on the individual's record, not on the postal code, not on the community, not—

Mr. Bas Balkissoon: When you say "individual location," I don't understand.

Mr. Bick Dhaliwal: Okay. When a particular person in Brampton or North Bay makes a claim, he can affect his or her insurance premium. Not everybody who lives in that neighbourhood—

Mr. Bas Balkissoon: No, but hold on. If you hit me and I have injury and I make a claim, my policy should not go up.

Mr. Bick Dhaliwal: No. I didn't say your policy should go up.

Mr. Bas Balkissoon: Okay. So it's the person who had the accident?

Mr. Bick Dhaliwal: That's right.

Mr. Bas Balkissoon: Just that one person?

Mr. Bick Dhaliwal: Just that one person.

Mr. Bas Balkissoon: Do you realize that if the insurance industry was to operate that way, then that one person would never get insurance again?

Mr. Bick Dhaliwal: That is something that insurance companies and the government legislation have to decide, how they're going to handle that. I'm just here as a citizen who has questions. The system is not working properly, and it has to be designed—

Mr. Bas Balkissoon: I understand that, but I'm trying to show you the fault in your own process. Insurance, as it's designed, is that we all pool our resources to look after each other.

Mr. Bick Dhaliwal: Yes.

Mr. Bas Balkissoon: Okay. That's the whole premise of insurance.

Mr. Bick Dhaliwal: Right.

Mr. Bas Balkissoon: It's a pooling of resources. So if you have an accident against me and I make a claim, it's not intended that just your policy go up; some of that has to be dealt with as part of the pool.

Mr. Bick Dhaliwal: Okay.

Mr. Bas Balkissoon: Okay. How you design the pool is an issue.

The second issue is, if everything was perfect, without the fraud, we wouldn't have a problem. So I'm asking you: How do you deal with the fraud? Did you come here with an idea of how the government should deal with the fraud?

The Acting Chair (Mr. Rick Bartolucci): We have two minutes left, Bas.

Mr. Bick Dhaliwal: I think that is the government's job to investigate and root out the problem—like you said, if the root cause is the fraud. Like any other criminal acts, the public doesn't say, "Okay. This guy commits a crime. This is how we should punish him." There's a system that is set up, and that is government's job, not mine.

Mr. Bas Balkissoon: Okay. Do you accept the two steps that the government took in 2010—and there's probably a whole lot more to do, and that is what is being done right now. In 2010, we allowed individual policyholders to make a choice of what benefits they have. My colleague across is telling you that since 2010, the insurance industry has had a huge savings and he wants those savings passed on, which none of us argue about. What we're arguing about is how we continue to deal with the fraud. The moves we made in 2010 are the first step. We're now looking at the second set of steps, which has been outlined, that we would take in the next little while. Would you agree that since 2010 the government has been going in the right direction?

Mr. Bick Dhaliwal: Yes, the government has gone in the right direction—

Mr. Bas Balkissoon: Thank you.

Mr. Bick Dhaliwal: —but also, there's—

Interjections.

Mr. Bick Dhaliwal: Yes. The government is doing the right steps, but at the same time, they are not controlling the escalation of premiums by the insurance companies. The government is doing the legislation things, but insurance is still rising on the people. You just saw a

presentation on Hamilton. This happened just in this year.

Mr. Bas Balkissoon: Thank you.

The Acting Chair (Mr. Rick Bartolucci): Thanks, Bas. We'll move over to the PCs and Todd.

Mr. Todd Smith: Thanks, Chair, and thanks, gentlemen, for coming in and answering our questions here this afternoon.

You're both taxi drivers?

Mr. Bick Dhaliwal: No, he's a taxi driver. I represent the taxi association.

Mr. Todd Smith: Okay. How much liability coverage do you need on your taxicab?

Mr. Bick Dhaliwal: Minimum $1 million to $2 million.

Mr. Todd Smith: One million to $2 million?

Mr. Bick Dhaliwal: Yes.

Mr. Todd Smith: Has this increased over the years, over the last couple of years?

Mr. Bick Dhaliwal: The liability?

Mr. Todd Smith: Yes.

Mr. Bick Dhaliwal: No.

Mr. Todd Smith: Why has that not increased?

Mr. Bick Dhaliwal: I'm sorry?

Mr. Todd Smith: Why has that not increased?

Mr. Bick Dhaliwal: That is something you have to ask the insurance company.

Mr. Todd Smith: But obviously, there have been more claims in the Brampton area, right? There has been an increase in the number of claims in that area.

Mr. Bick Dhaliwal: That's what we've heard, but I haven't seen any stats or any numbers—how many, in what area and how much they were paid out. That information is not available.

Mr. Todd Smith: I know that in the meetings that we've had, the payouts have been much more in that area.

Mr. Bick Dhaliwal: Yes, I heard that, but I don't have the figures.

Mr. Todd Smith: So payouts are very much more in that area.

I guess the other question we need to get to is—you know, we've been talking a lot about taxi drivers and taxicabs here so far today—taxis are considered commercial vehicles?

Mr. Bick Dhaliwal: Yes.

Mr. Todd Smith: So this insurance deduction that we've seen proposed here by the two parties is aimed at personal vehicles, right? It's not aimed at commercial vehicles?

Mr. Bick Dhaliwal: Exactly.

Mr. Todd Smith: So what we're discussing in the Legislature at this time isn't going to affect taxi drivers at all?

Mr. Bick Dhaliwal: It's not going to affect it, but like I said, going to the Facility insurance like they did in Milton and London—that is the fear that has been around the community, and they feel, if it comes to that, it's going to have a drastic effect on the community as a whole.

Mr. Todd Smith: Right. I'm really curious, and I don't know if you can answer this or not, why Brampton, obviously, and that area has been the hot spot as far as the conversation goes on increased insurance rates.

Mr. Bick Dhaliwal: Right.

Mr. Todd Smith: Why have we not experienced the same kind of increases, or the same problems, I guess, for taxi drivers in Brampton that we've seen in Hamilton and London? Is there any reason why they're not able to get insurance in Hamilton and London but you're still able to get insurance in Brampton? I'm curious as to why, if Brampton is the epicentre of this whole problem and where the insurance rates are the highest, have we seen the situation unfold in the way it has to our southwest?

Mr. Bick Dhaliwal: I think we are talking about two different things right now. As for the private insurance, Brampton has it much higher than any other municipalities. What happened in London and Hamilton, that was a taxi issue, and now we're talking two different things.

So when we talk about the private insurance, Brampton residents are charged much more premium because of just being in Brampton, and if they give the same information over the phone to the broker, using a different postal code, their insurance even comes down, 30% to 50% down, which is totally unfair—just because of the postal code.

The second one you mentioned was the taxi industry. The taxi industry in the Brampton area are in fear that what happened in London and in Burlington could happen to them. So those are the two separate issues there.

Mr. Todd Smith: And I think what we may find out is that there would be more accidents involving taxicabs or more claims involving taxicabs in those areas than there are in Brampton. Would that be a logical conclusion?

Mr. Bick Dhaliwal: Well, again, that's something that I cannot predict, how people drive in one city versus how they drive in the other or as a whole. Those stats are not there, and this is all just speculation, and I don't really want to make any comments on the speculation.

Mr. Todd Smith: Fair enough. You mentioned the Fraser report when you started off, right?

Mr. Bick Dhaliwal: Yes.

Mr. Todd Smith: Do you happen to recall what the two biggest cost drivers were in the Fraser report when it comes to auto insurance?

Mr. Bick Dhaliwal: I don't remember if I had the opportunity to print it out, but if you could—

Mr. Todd Smith: I believe fraud and bureaucracy were the two biggest drivers of—

Mr. Bick Dhaliwal: Exactly, yes, they could very well be, and I mentioned that in the beginning of my speech also.

But there has to be a common denominator. We cannot just use one—like a fearmongering kind of thing, just use the word "fraud" and increase everybody's insurance

premiums. It has to be justifiable, it has to be open, and it has to be debated and analyzed and changed. So I believe there has to be more openness in the concept from the insurance company, and all we hear is just the word "fraudulent"; "fraudulent," but there aren't any proper figures, how much they're generating and how much they're paying out. That will really open a lot of unanswered questions.

Mr. Todd Smith: I actually hail from New Brunswick, and they had a similar problem in New Brunswick a number of years ago. They had large increases when the territories changed in New Brunswick a number of years ago. Their solution in New Brunswick was to actually allow more territories, and that seemed to level out the increases across the territories. Do you think that's a viable solution for the province to consider or for the GTA to consider, for that matter?

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Mr. Bick Dhaliwal: I agree with that as long as the insurance—the main purpose of our being here today is to have consumers get some relief from the pressure that they're feeling right now. So creating a territory or any other alternative that would give them relief would be viable.

Mr. Todd Smith: Insurance is a risk-based type of enterprise, right? The insurance companies are obviously feeling that, because most of the claims and the expensive claims are coming from your part of the province, that's why the insurance is so high there. I don't think we can dispute that fact. I've actually seen a map of the province where it shows where most of the dollars are paid out, and it happens to be in that northern part of the GTA.

So I can tell you, being a representative from eastern Ontario, where it's probably the safest place to drive in the province, that the insurance rates are much lower and they would like to keep them that way, obviously, in the eastern part of the province. North of Toronto, it's more expensive. It has been told to me—and you mentioned the Fraser report off the top—that the biggest reasons that exist are the fraud that exists in that area.

We've seen in other jurisdictions—and I mentioned what they did in New Brunswick but also in the state of New Jersey, where they came down hard on fraud in that state, and it has made a huge difference in New Jersey.

Mr. Bick Dhaliwal: Yeah. Well, I agree with what you're saying and with the Fraser report, but I also feel that the word "fraud" has been overused in this industry just so they can charge more premiums. I think there has to be in-depth research that has to be conducted so that the facts can be heard. We should not speculate on the words when the insurance companies say there's fraud, but as long as we as consumers know what those figures are so we can be at least justified. Even if the insurance premiums do go up, we should know why they went up.

Mr. Todd Smith: Thanks.

The Acting Chair (Mr. Rick Bartolucci): Thank you very much, Mr. Dhaliwal. Mr. Singh, thanks very much for your presentation and for answering the questions in such a frank and open way. Thank you so much.

Mr. Bick Dhaliwal: Thank you so much.

CANADIAN ACADEMY OF PSYCHOLOGISTS IN DISABILITY ASSESSMENT

The Acting Chair (Mr. Rick Bartolucci): The next presentation is from the Canadian Academy of Psychologists in Disability Assessment. Brian Levitt is the president.

Brian, welcome.

Dr. Brian Levitt: Thank you. I'm just going to take a moment to set up the PowerPoint.

The Acting Chair (Mr. Rick Bartolucci): No problem.

Okay. Are we ready, Brian?

Welcome, Brian.

Dr. Brian Levitt: Thank you. Thank you, first of all, for having the time to hear from us today. I'll be starting with just basically explaining who we are, whom we represent and why we're speaking with you.

I'm Dr. Brian Levitt. I'm the president of the Canadian Academy of Psychologists in Disability Assessment. I'm a clinical and rehabilitation psychologist, and I'm here as the president of the Canadian Academy of Psychologists in Disability Assessment.

To my left is Dr. Ron Kaplan. He's a clinical and rehabilitation neuropsychologist and is here as a consultant. He's a founding member of CAPDA, which is the organization that I'm representing today.

CAPDA members are senior psychologists. We specialize in disability assessment. In particular, we have many members with unique expertise in carrying out catastrophic impairment assessment, and that's what I'll be focusing on today.

Many of us were on the FSCO roster of CAT assessors; two owned and operated one of the seven CAT DACs. We have members who have served on the minister's committee on the DAC system; the recent expert panel; various committees to review DAC guidelines; and various HCAI committees. We have given many courses and lectures on catastrophic impairment to doctors and lawyers.

I have published the only scientific papers on catastrophic impairment in Ontario, and of course I'm happy to provide you with copies. I'm also happy to try to explain my understanding of this confusing and complex area.

There's a recent IBC advertisement just outside Queen's Park; I noticed today coming up it's still out there, actually, in front of the Frost building. One of the things that it says is: "Define catastrophic injury based on medical science—not on lawyers' arguments." We agree.

This just came out a couple of days ago, from the Canadian Underwriter: IBC's president and CEO "noted that the government's proposal to have further consultations on the catastrophic impairment definition [is] unnecessary, since it's already been studied extensively." We disagree.

There is a lot of misinformation; I cannot address it all in 10 minutes, but I welcome your questions.

The expert panel's approach to recommendations for mental and behavioural impairments was flawed and incomplete. The expert panel did not have the resources to examine the issue, for example, of combining mental and behavioural impairments with physical impairments, and they said so; this is in their report.

The catastrophic impairment definitions have not been studied extensively enough. The government is looking for something reliable; we understand that, and we also would want something reliable as scientists. The expert panel made some proposals that are more reliable, but they did this only by using criteria that result in more false negatives—in other words, raising the bar so high that a lot of people who should be considered catastrophic are left out in order to make it easier to determine catastrophic. As I say, in other words, they sacrificed the needs of a small group of seriously impaired patients to achieve greater reliability. As scientists, we think that reliability begins with method, not by changing definitions. You have to start with method; if you just change definitions, you're still leaving method out. So you're still going to have an unsound foundation.

This is an essential point and a significant flaw in the approach that was taken by the expert panel. You don't have to make a definition more restrictive and exclude a small group of people in great need in order to achieve reliability. A standard method is what's needed to achieve reliability. This is how we work as scientists; if we all have a standard method that we all follow, then our results are more reliable. It's the foundation of what we do.

This was the case under the former DAC system; and with the dissolution of the DACs, assessors have no common guidelines for their method. It's the Wild, Wild West. Methodological guidelines should be written into the SABS CAT definitions to reinforce them for all assessors to follow.

Luckily, the AMA guides' fourth edition is already written into the SABS as a part of the definitions. The guides provide a rich method; it is very detailed and robust. We are asking that it be required to be used by being more explicit about this in the SABS definitions—that assessors actually use the guidelines that are written in the AMA guides.

Regarding SABS definition (e), the combination of impairments resulting in 55% whole-person impairment, the proposal to disallow inclusion of impairments due to mental and behavioural disorders is discriminatory; I don't know any other way to put that—it just is. It is also contrary to research and science regarding the compounded impact of coexisting physical and mental and behavioural disorders.

The fourth edition of the AMA guides, chapter 4, table 3, should be applied to quantify impairments due to mental and behavioural disorders, to be combined with other impairments for a whole-person impairment rating. The combining method used in the guides discounts impairments that are combined so that the total impairment rating can never be greater than death. I'm not sure if this is a point that's well understood in the public, but the idea in the guides is that you have an impairment percentage for each kind of impairment; if you have multiple impairments, if you don't have a way of discounting them, you could exceed 100%, which is more than death. Whenever you combine multiple impairments, there's a discounting method, so each impairment actually has a lower impairment rating than it would have on its own. This is, as I say, a convenient mathematical fiction, but it does not represent the actual increased impairment burden when a patient has more than one impairment of any kind. Any consideration of combining should not allow further discounting of mental and behavioural impairments, because the combining method already discounts multiple impairments. That's the nature of how the guides approach this.

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Regarding SABS definition (f), which is impairments due to mental and behavioural disorders, the indicia as proposed by the expert panel are essentially useless. They are also arbitrary, and they are harmful. While the indicia proposed by the expert panel are more objective, they're not in line with reality. This is a point that I really hope to underscore. These days, a huge number of people are managed at home or are hidden because of cultural factors, family factors and the ongoing stigma of mental illness. In other words, having indicia about hospitalization means you're going to be missing that portion of the population that is not being hospitalized for all these reasons.

The expert panel also proposes a GAF of 40 or less. The GAF is a part of how we diagnose in psychology and psychiatry. This is the equivalent of precluding all functioning. It's a very strict, high bar. By contrast, the loss of a limb, which is considered to be a catastrophic impairment, can be expected to significantly impede useful functioning but not preclude all functioning.

The Acting Chair (Mr. Rick Bartolucci): Two minutes, Doctor.

Dr. Brian Levitt: Further, those with persistent mental disorders may never recover and may need ongoing care and treatment supports to prevent further deterioration. By contrast, amputees with proper treatment and new prostheses may return to almost normal functioning.

Also, there's no clinical or research basis to shift from the AMA guides to a GAF model. The GAF has long been a fixture of the DSM, but DSM-5 will no longer use it. Also, in Canada and the US, the way we'll be diagnosing in health care, we'll be relying on the ICD, the International Classification of Diseases, and moving away from DSM and GAF.

Chapter 14 of the guides provides a robust method for an assessment with explicit directions to arrive at valid and reliable determinations of impairments resulting from mental and behavioural disorders. Retaining and reinforcing the method used in chapter 14 by writing it

into the SABS definitions addresses concerns regarding reliability.

Finally, regarding SABS (d), brain impairment, the proposed removal of the Glasgow coma scale without any replacement for early identification is very problematic. Scientific evidence documents the higher needs of patients with brain injuries in the early post-injury phase, when it may not be possible to predict ultimate outcome using measures of current function. The GCS was put into the SABS because it is available in almost every medical file. It allows an insurer to make a quick determination if a patient has a cat brain injury. It's cost-effective.

Cat myths: Please ask me about these. I'm happy to talk about any of them.

The Acting Chair (Mr. Rick Bartolucci): That's where we're going to have to cut you off. Your 10 minutes are up. Maybe we can capture the rest of your presentation while you're answering questions. All right? We'll turn it over to the Liberals, who will go first.

Mr. Bas Balkissoon: I just have something very simple, because you've just baffled me with a lot of medical terms. Do you see in the system that the government develops that, whatever we put in policy, procedure or law, there will be a certain percentage of the population who are victims of an accident that must proceed through a court and let a judge decide on all these medical factors?

Dr. Brian Levitt: Absolutely.

Mr. Bas Balkissoon: Okay, so you agree with that process. In defining these major injuries, our goal really is not to capture everybody in it. Would you agree with me?

Dr. Brian Levitt: I understand, yes.

Mr. Bas Balkissoon: Okay, thank you. Mr. Chair, I'm finished.

The Acting Chair (Mr. Rick Bartolucci): Great. Any other questions? All right, we'll go over to the Progressive Conservatives. Laurie.

Ms. Laurie Scott: Thank you very much for coming today and presenting to us. It was pretty high-level for those not in the medical profession. I just wanted to know: Do you want to finish off some of your slides? I'll let you do that, and then I have a couple of questions.

Dr. Brian Levitt: I'd appreciate that if I could—

Ms. Laurie Scott: If you don't mind putting it in kind of more language that we might understand. I have a bit of a nursing background, and you've certainly worried me in what you presented.

Dr. Brian Levitt: Excellent, thank you. I'll be very brief with it; it's just a list of common misunderstandings about catastrophic. The next eight or so slides are just the common myths about catastrophics.

Ms. Laurie Scott: That's fine, okay.

Dr. Brian Levitt: One myth is that anyone with chronic pain can be declared catastrophic now, and the floodgates have opened; that's a myth. Combining physical with mental behavioural impairments opens the floodgates; that's also a myth.

Mental disorders are subjective and easily faked; that's a myth. The chapter on mental and behavioural disorders is less reliable than the other chapters in the guides; that is also a myth. All mental disorders are temporary; not true. The GAF is a good replacement for the methodology and classification system in chapter 14 of the guides; not true, that is a myth. Mental disorders produce less disability and less burden on the person in care systems than physical disorders; also not true. Mental disorders don't have much impact on physical disorders; that is a myth. Mental disorders should be discounted if they're combined with physical impairments; that is untrue.

The SABS catastrophic impairment definitions are numerical equivalents; that's a myth. And psychologists do not assess, diagnose and treat patients with severe mental illnesses. Of course we do; that is a myth. Psychologists are not qualified to do catastrophic impairment assessments and sign OCF-19s; that's also a myth. Of course, we are qualified to do so.

Ms. Laurie Scott: So I guess I'm quite worried about the fact that we have this new definition of "catastrophic." I think that's what occurring, but you—

Dr. Brian Levitt: It's being proposed.

Ms. Laurie Scott: Yes, it's being proposed. You certainly don't agree with it, from my—

Dr. Brian Levitt: I have significant disagreements with the expert panel proposals, yes.

Ms. Laurie Scott: Okay. The expert panel has obviously said, "We didn't have funds to do some of the comparisons or assessments."

Dr. Brian Levitt: Correct.

Ms. Laurie Scott: So why would they remove the Glasgow scale, and why would they move to a GAF model? The AMA, I'm taking it, is what you would prefer was used. You can elaborate on any of those points that I've just said.

Dr. Brian Levitt: I see what you're saying. The GCS actually refers to a different definition in the SABS about brain injury. The moving towards a GAF has to do, in general, with mental and behavioural disorders. There were proposals by the expert panel to move away from the guides that we have long used and have a pretty robust method for doing assessments for coming up with impairment determinations and trying to come up with something. As I was saying, the indicia—

Ms. Laurie Scott: So indicators, is that what—

Dr. Brian Levitt: Indicators, yes: So someone should have had psychiatric hospitalizations, someone should have certain medications, that sort of thing. It simply doesn't happen all that much, because of cultural and family factors etc. So you're leaving out a very important sector of a small group of people who are severely impaired by setting up indicators that don't mirror reality.

Then setting up a GAF—the issue with a GAF—there are a number of issues. One of them, though, is that the GAF is simply a measure; it's not a method. The AMA guides provide a very detailed, rich method in chapter 14 for doing an assessment of mental and behavioural

disorders and then for being very transparent about how you make your impairment ratings, how you lay it all out. The GAF has nothing to do with that; it's just one simple measure. So if you move from the AMA guides to the GAF, you're actually losing reliability; you have no method.

Ms. Laurie Scott: We're in this room, and some have medical backgrounds and some don't. We're in this political position, and there has been a recommendation for the new definition of "catastrophic." Yet you've presented a very different point of view. What is one in our position to try and do? Have you presented an alternative definition for "catastrophic"?

Dr. Brian Levitt: Thank you for that question; I do appreciate that. I think what I'm arguing for is that the definitions, as they are, I believe, can be improved in terms of reliability by including in the definitions a reliable method to follow. The guideline should be in there about how you follow these definitions, because if you simply change the definitions, you still don't have the foundation of a consistent method that everyone uses. You can keep changing the definitions and changing them, but the problem is, these were changed—I think the philosophy was, and I'll put it in very kind of—

Ms. Laurie Scott: Layman's terms.

Dr. Brian Levitt: —gross terms, very blunt terms. It's very easy to go to a cemetery and for everyone to say, "Yup, they're all dead." That's reliable. You walk up, and you see all the graves. Everyone's dead. So you can set your definition so strictly that of course it's reliable, but you're going to be leaving out an important small group of people who should be deemed catastrophic in order to get the treatment needs. Instead of changing the definition and making the bar so high so as to make it reliable—as scientists, the place we always start is our method for how we go about assessing people. If we all have a method that we all have to follow by law, that's the foundation of it. Changing your definitions without having a foundation is not going to help. That's my basic argument.

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Ms. Laurie Scott: Okay. That's fair enough. I think you could argue that you can actually speed up this process if there was proper methodology in place for people with catastrophic injuries.

Dr. Brian Levitt: I think part of what would happen, if there was proper methodology that everyone followed, there should be less disputes because we're using a common method.

Ms. Laurie Scott: Right.

Dr. Brian Levitt: So the dispute resolution system would be helped by that.

Ms. Laurie Scott: Okay.

Dr. Brian Levitt: That's exactly what I'm saying.

Ms. Laurie Scott: Okay. Very good. Thank you very much for coming today.

The Acting Chair (Mr. Rick Bartolucci): Thanks very much. We'll now move to the NDP. Jagmeet.

Mr. Jagmeet Singh: Thank you so much. I want to take some brief time just to go through and kind of summarize some of the ideas here. One of the things I want to be clear on: There was an expert panel that tried to come up with a new definition, and some of the problems with that new definition—one is, the expert panel itself was flawed. If you could quickly and briefly provide one clear example why that expert panel was flawed.

Dr. Brian Levitt: The most basic example of how it was flawed is that the expert panel followed what we call a Delphi method. However, they didn't follow the Delphi method the way the Delphi method should be followed. The idea with the Delphi method is that you're supposed to have a big enough number of people so when you have disagreements, if a large enough amount of people agree, you can say you have consensus. The expert panel was eight people. They're covering a wide range of issues that you can't represent with just eight people. Six out of eight is considered consensus. So if two people disagree, the expert panel's findings are still issued as a consensus.

The problem is, for example—and I'm talking about just mental and behavioural impairments today—there was only one practising psychologist on the panel. So six people could say, "Oh, yes, this is a great idea for mental and behavioural impairments." The psychologist could disagree and the expert panel's findings are a consensus that that definition is all right. It's a very significant flaw, and it kind of gets brushed over.

Mr. Jagmeet Singh: And just to put that into more context, essentially anything that dealt with mental or behavioural issues, the one key expert in that area—there was only one individual, and if you needed six people for consensus, that one person's viewpoint could be marginalized all the time.

Dr. Brian Levitt: That's exactly what I'm saying.

Mr. Jagmeet Singh: Okay. And there's no surprise, then, in the definition that there is greater emphasis placed on the physical injuries leading to a definition of impairment or catastrophic impairment, but there's much less emphasis placed on mental or behavioural illnesses. Is that correct?

Dr. Brian Levitt: I think even more so than that, what I would say is that because of that imbalance in the panel, you actually see discrimination with respect to mental and behavioural impairments.

Mr. Jagmeet Singh: So, to put that bluntly, people with mental or behavioural issues or impairments were essentially not considered to be serious impairments.

Dr. Brian Levitt: Unfortunately, because I think the composition of the panel did not represent those experts who would understand those issues well enough.

Mr. Jagmeet Singh: Okay. I think you touched on this point very well, but just to go back to it again: If the goal is to create a more reliable way of measuring who is catastrophically impaired or not, to create that reliability, you can create that by having a method of assessing someone; and making the method more reliable would create a more reliable result as opposed to making the definition more strict or less strict. That's not the way to get a more reliable result.

Dr. Brian Levitt: Exactly. That's the scientific method. If we all have an agreed-upon method to follow, reliability means that we both do the same thing, so we're likely to come to similar conclusions. So you have to have a common method.

Mr. Jagmeet Singh: And just talking on the combining of factors, what went on in this, the way the new definition is proposed, is the combining factors and the discount. So, essentially, if you have two serious impairments and you're combining a mental issue and a physical issue, first of all, you are not allowed—the new definition is not encouraging the combining of those two factors. Is that correct?

Dr. Brian Levitt: What I understand is, the expert panel didn't have time to consider combining.

Mr. Jagmeet Singh: Okay.

Dr. Brian Levitt: So that there's nothing to even look at from the expert panel.

Mr. Jagmeet Singh: Because the reason why this is being raised is that, in fact, if you have a mental impairment with a physical impairment, both of those issues would be exacerbated, both your mental impairment as well as your physical impairment, if you have both of them.

Dr. Brian Levitt: That's right. I can tell you, as a practising clinician, what we see is that when people have both physical and mental/behavioural disorders, it's harder to treat both.

Mr. Jagmeet Singh: Okay. And just on this issue of the GAF scoring, if you lose a limb, technically, in terms of your functioning in society, you are still able to function at a pretty decent level in some circumstances. Losing an arm or losing a hand: you would still be able to function at a quite high level. Whereas if you had a significant mental impairment, you may not be able to function whatsoever in society, but that would result in a lower score than someone who lost a limb.

Dr. Brian Levitt: That's what I'm concerned about in terms of the expert panel's recommendations; exactly.

Mr. Jagmeet Singh: So that someone who actually can return to somewhat of a normal life would be perhaps deemed catastrophic, and maybe rightly so, but someone who couldn't get back to a normal life whatsoever but didn't suffer a significant physical loss like a loss of limb—that person, though they were functioning at quite a low level, would not be considered to be catastrophically impaired.

Dr. Brian Levitt: That's exactly right.

Mr. Jagmeet Singh: Okay.

Ms. Teresa J. Armstrong: I have a question.

Mr. Jagmeet Singh: Sure.

Ms. Teresa J. Armstrong: You had said that the scientific findings of how they're going to determine catastrophic have—determined by the panel. You mentioned that it was because of time, that you didn't have enough time to go beyond that procedure.

Dr. Brian Levitt: My understanding, from what they issued, is that they didn't have the resources, which I figure would be—

Ms. Teresa J. Armstrong: Funding?

Dr. Brian Levitt: —time and funding, in order to go into that.

Ms. Teresa J. Armstrong: Okay. So they haven't done a thorough investigation or a comprehensive look at the definition of catastrophic. Wouldn't that be even worse, to change a definition and having to fix that mistake later? How do you feel about the fact that if they do proceed—has the government done its due diligence in actually getting it right?

Dr. Brian Levitt: In my opinion, the government wouldn't be doing its due diligence. You're restating basically what I was saying in terms of, if you change the definition without having looked at it thoroughly and without understanding that method has to be a foundation, you're going to end up with a mess on your hands.

Mr. Jagmeet Singh: And how many people were we impacting in the first place? How many people were we impacting in terms of the number of people who are actually deemed catastrophically injured and what's the cost associated with that to provide any basis for even reducing that number or the argument that—I'm suggesting it's already such a small number of people that there's no basis to make that number even smaller.

Dr. Brian Levitt: From my understanding, it's probably about 1% of accident victims. So it's already a very small group of people, but then, these definitions—as a psychologist, I see them unfairly discriminating against those with mental and behavioural impairments, a very small group.

Mr. Jagmeet Singh: And one of the points you had mentioned, just to clarify, when you indicated that for the mental side that the requirements are so high—one of the things you talked about was that for someone to be deemed mentally impaired enough to meet the definition of catastrophically impaired, some of the requirements were that they would be institutionalized and be on specific medications.

Two issues: One is, someone could be significantly mentally impaired but not actually be institutionalized. Folks who don't have access to an institution, to get into an institution in the first place, would be mentally impaired but not able to get into an institution, would not be covered.

You also talked about cultural barriers, that if you're part of a particular community that—well, in many communities, mental illness is stigmatized and they wouldn't want their loved one or their family member to actually go to an institution, though they might qualify as someone who should be institutionalized. Because they're not institutionalized because of cultural barriers, they wouldn't be recognized as someone who is catastrophically impaired. Am I understanding what you're saying?

Dr. Brian Levitt: That's exactly right. I can't say it any better than that.

The Acting Chair (Mr. Rick Bartolucci): Two minutes, Jagmeet.

Mr. Jagmeet Singh: Okay. Unless my colleague has more questions, is there anything else that you feel has

not been covered that you would like a couple of minutes to cover?

Dr. Ron Kaplan: I'm Dr. Kaplan. Let me just address the question about the numbers and the costs. We know that HCAI is not collecting data on the number of individuals with catastrophic impairment. So we're always relying on somewhat informal data about the number of people applying for catastrophic impairment and being determined catastrophic impairment. Of course, we don't know about the value of the benefits they receive or the settlements they receive, so we're always in the dark.

We should remember that catastrophic impairment—when an insurer accepts that you have a catastrophic impairment, no money changes hands. The insurer is simply saying that your entitlement to apply for further benefits has changed. So if you can demonstrate that you need attendant care, you now have access to attendant care at the quantum that's appropriate for your needs. If you've run out of the basic policy level, you can now apply for further treatment dollars, but it doesn't mean that you're automatically going to spend the limit of $1 million plus $1 million over your lifetime at all. The system has that second control that nothing is provided unless it's shown to be reasonable and necessary, and the insurers are able to get their own insurer examinations to determine if an application for either attendant care or treatment is necessary. So catastrophic impairment determination allows a person to apply for further benefits; it allows nothing further.

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Mr. Jagmeet Singh: That's very, very useful. Thank you.

The Acting Chair (Mr. Rick Bartolucci): Doctors Levitt and Kaplan, thank you very much for a very insightful presentation. Have a wonderful day.

Mr. Mike Colle: Mr. Chairman, a point of order. Just to make sure that we're keeping track of the acronyms—I think we're up to about 87 now: DACs, AMAs, WPI, SABS, cats, GCS. The researcher is still doing it? Thank you.

The Acting Chair (Mr. Rick Bartolucci): Right. Okay.

ONTARIO PSYCHOLOGICAL ASSOCIATION AUTO INSURANCE TASK FORCE

The Acting Chair (Mr. Rick Bartolucci): Our next presenter is from the Ontario Psychological Association Auto Insurance Task Force: Amber Smith. Amber? Perfect.

Dr. Amber Smith: Thank you. And I have with me Dr. Faith Kaplan.

The Acting Chair (Mr. Rick Bartolucci): Great. Welcome.

Dr. Amber Smith: Thank you. We're both members of the OPA task force.

The Acting Chair (Mr. Rick Bartolucci): Amber, go ahead.

Dr. Amber Smith: Thanks. We wanted to start by reminding you all of the purpose of accident benefits under the SABS, the statutory accident benefits schedule: to provide timely access to funding for services. Of course, impairment and benefits include psychological and rehab benefits, and are meant to reintegrate the person into their family, the rest of society and the labour market, and to reduce disability due to those impairments. That's the starting point for everything.

Psychologists are independent and autonomous regulated health care providers. We're trained from the bachelor's to the doctoral level in normal and abnormal mental health. We're experts in scientific methods applied to health and behaviour, and we're experts in measurements. We provide scientifically valid and reliable methods for assessing impairments; cost-effective, empirically validated, evidence-based treatments; and gold-standard interventions for depression, anxiety, brain injury and chronic pain.

In Ontario, we see patients with traumatic injuries under WSIB auto victim services and private health plans. We're employed in specialty clinics and hospital programs for chronic pain, depression, anxiety disorders, schizophrenia, cognitive impairments and brain injuries, but we cannot bill OHIP directly. We are not available under OHIP.

Why fund psychologists under auto? Car accidents are the single biggest cause of civilian post-traumatic stress and brain injuries. Psychologists provide the most effective treatments for PTSD, and we're the only profession able to measure and diagnose cognitive impairments due to brain injury. For accident victims, we assess and treat PTSD, depression, chronic pain, traumatic grief and brain injuries. We help people get back to school and work, and we assess and measure disability.

We tend to be involved with the most seriously injured and vulnerable patients. We work with those high-needs victims with brain injuries and psych disorders. We are critical to help them prevent disability. Historically, it's only about 2% to 4% of services in Ontario—med rehab—that are to psychologists, so we see a very select proportion of very vulnerable people.

As you know, mental health is extremely misunderstood. Services are historically underfunded. We have studies across the country that tell us this time and time again, and auto is no different.

This is a very large slide with a lot of information referring to something that just came out from the Canadian Psychological Association that talks about the severe gap in the ability of patients to receive psychological services that are evidence-based, scientifically valid and the gold standard, but patients can't reach them, and from the FSCO website talking about how many goods and services required to rehabilitate people are not available under OHIP. You'll get the slides and we can provide this if you'd like it.

Auto accident victims' injuries are invisible, an easy target for stigma, misunderstanding and discrimination, and they have high rates of disability.

The OPA has evidence-based guidelines for assessment and treatment services that are billable under auto insurance, developed by over 20 psychologists in the province, that were published in an international peer-reviewed journal.

The OPA auto task force committee—Faith Kaplan is co-chair—and the HCAI anti-fraud committee participated in the professional identity tracker. Many of our members really enjoyed that and gave feedback on how to make that product better for the anti-fraud initiative. We're currently developing joint guidelines for IE assessments—that's insurer examination—and MIG determinations with our colleagues in CAPDA.

Interjection: That's minor injuries.

Dr. Amber Smith: Minor injury, I see. MIG, minor injury; my apologies.

When we presented to the standing committee last year, we presented our concerns that the 2010 reforms were resulting in harm to legitimately injured people with brain injuries and psychological impairments. When we presented to finance and economic affairs in July, we presented data indicating that the reforms had resulted in significant improvements to cost control for the insurance industry, for which we were very glad. However, we also presented data from reputable clinics outside the GTA that indicated approvals for recommended assessment and treatment services had decreased significantly since the reforms.

Here's one of those slides. You can see the difference. This is in a very, very high-quality ethical clinic that sees a lot of very brain-injured and vulnerable people. You can see those approval rates have changed significantly from 2010 to 2012.

Here's another slide where you can see the difference from 2008-09 to August 31, 2010, and then on the bottom, after September 1. You can see the reduction in the approval rates and the increase in the denial rates. These are very ethical, high-quality clinics outside the GTA, not committing fraud, following standard guidelines.

As a result, we indicated our concern about disputes, disability, increasing tort and BI costs, more mediation and arbitrations, and increased cost to the public systems. We also said that we were very concerned about what was happening with our patients: more frustration, more assessments, less treatment, delays without resolving disputes and more problems for our injured patients.

In August, we were very pleased to present to the anti-fraud task force. We told them how many of their recommendations were consistent with what the OPA had been recommending for years. We love quantifying. We love putting numbers to things. This was all good and we were really pleased to be a part of it.

We recommended to them that they assess the successes that had been achieved by the 2010 reforms before enacting more intrusive and costly additional regulation, making sure that they protected patient privacy and due process in any investigations of fraud—and that we would like to be a part of any implementation, discussion and planning.

Today, we want to follow up with you to provide an update on what we're hearing from our members about assessment and treatment. AB costs continue to be down from what we see. Fraud initiatives come into effect next month—that's awesome. Approvals for reputable assessment and treatment services, unfortunately, continue to be down. What are the effects on insurance examinations? What's happening with minor injuries? And what does this mean for our patients?

We polled members whom we knew to be active in auto insurance and whose practices we knew to be reputable. We got replies from these different locations. All reported referrals to their IE practices down 50% to 90% since 2010, and most were reviewing fewer excessive applications. Outside the GTA, they never really saw that many excessive, over-the-top applications to begin with, but inside the GTA, they said that there was a really significant reduction in the applications they were seeing. I got more last night that was consistent with this. So IE referrals seem to be down, bad applications seem to be down, but all respondents indicated that they're being asked more questions in each referral, especially in the GTA. Outside the GTA, the numbers were increasing, but it wasn't so bad; inside the GTA, up to 32 questions in one referral—and they're being asked to answer more questions for lower fees. They were forced into flat-fee agreements with the IE vendors. Sometimes they have to work for free to get the job done in a high-quality way.

We also heard reports about off-loading to the hospital systems, some people waiting over a year to be seen by psychology within the hospital system, ER visits increasing and wait-lists growing.

The Acting Chair (Mr. Rick Bartolucci): Two minutes, Amber.

Dr. Amber Smith: Okay. In Hamilton, they're looking at studying it and quantifying it because they're seeing it at St. Joe's and Joe Brant.

Excessive applications inside the GTA appear to have decreased—more cost pressures, more off-loading, more people accessing our fractured mental health system that can't handle the increase. Psychologists are doing more for less. There's more competition in the marketplace. Consolidation of IE companies has made people hypervigilant, I think, about costs and fraud. Approved plans are being trimmed. The minor-injury cap seems to be creating effective gatekeeping, but now people are having difficulty figuring out who's in and who's out.

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Our traumatized patients are having to go through an extra in-person examination to reveal all their trauma memories before they can even be seen to be treated. This is a significant problem. If a physician diagnoses PTSD, refers to me for assessment and treatment of PTSD, my screening indicates PTSD and then they're sent to a person they will never see again to disclose all their traumatic memories before they can even see me at all.

If someone follows guidelines and appropriate method, they should be able to have a paper review if you

need to—some other process—without having to be seen by an in-person IE. It's an additional cost and an additional barrier.

So now we see that there's a system-wide focus on rehab providers as being too fraudulent or too costly and every patient as being fraudulent. No one is neutral. It's creating a dual burden on patients of both presumption of fraud and micromanaging of costs. We have shorter plans, more partial approvals. It means less proper, effective momentum toward improvement. It's really difficult for our patients, and they're very vulnerable already.

The result is choppy, watered-down care. We hate to see this small percentage of vulnerable injured people injured further by a system that prejudges them to be fakes and liars and continually questions their need for more. We are hoping for more sophisticated targeted approaches to fraud.

The Acting Chair (Mr. Rick Bartolucci): All right. Thanks very much, Amber. You should thank the PC caucus because they've given some of their time so that you could finish.

Dr. Amber Smith: Thank you. I did time it, but I—you know.

The Acting Chair (Mr. Rick Bartolucci): Laurie?

Ms. Laurie Scott: It's actually a very complicated topic, so you did quite well. Did you want to add anything more to finish up? Because you can, I mean—

Dr. Amber Smith: Really, mostly what I wanted to convey is that we understand the difficult position that you're in, and we want to provide you with valid, reliable data, not just impressions and anecdotes from around the province. We want to provide you with good data about that small proportion of people whom we see. We recognize that it's a small proportion, but they are extremely vulnerable, and they create high costs. So we want to be able to provide good data so you can create sound, realistic policy that will help them.

Ms. Laurie Scott: Okay. I appreciate that. I just wondered, when you were saying about the PTSD—that's post-traumatic stress disorder, right?

Dr. Amber Smith: Yes.

Ms. Laurie Scott: Do you want to follow through an assessment that person would do, just to give us an example? Just because I think people just need to hear what kind of assessment they're going through now, and maybe add on what you'd like to see it changed to.

Dr. Amber Smith: Well, if this wasn't for auto insurance, I could start with what the troubling event was in the person's life, ask them about the event that may or may not have been traumatic for them, ask them to fill in some scales, speak to someone who perhaps knew them well and could tell me what they saw.

PTSD is a disorder of avoidance. One of the key features is that they do not want to talk about, think about, look at, hear anything related to what created the trauma in the first place. So it's a very difficult interview, a very difficult assessment to do. You have to ask very specific questions or the main response is going to be "nothing's wrong," when really they're very impaired.

Under auto insurance, we also have to get at the issue of whether they had anything before the accident that we're not supposed to treat. Was this entirely due to the accident, and is it something that's actually impairing their function that, therefore, needs to be rehabilitated? So we have an extra layer of adjudication we have to do in our assessments.

We also like to speak with the family physician, get some medical files, make sure we understand the person's history. We have to do a far more robust investigation and assessment than we would in just a general mental health clinic because of the adjudicated piece—

Interjection.

Dr. Amber Smith: And about treatment: Treatment can be protracted. It's very difficult. There has to be a series of graded exposures to the traumatic memory. When you have something like chronic pain in there on top, the pain actually acts as a trigger for the traumatic memory, so it makes it more difficult to treat. Then, if you have depressive amotivation—lack of motivation—on top, it makes them even less likely to want to do this. So treatment when you have that and then a brain injury on top is beautiful.

But treatment for these patients can be very challenging. So when you have this chopped-up care, it's really not ideal.

Ms. Laurie Scott: So, really, you're discriminated against if you have post-traumatic stress disorder due to an auto accident—

Dr. Amber Smith: Yes.

Ms. Laurie Scott: —which is what the previous group was trying to point out.

Dr. Amber Smith: If you have a sprain or a strain, and perhaps you have something more physical that someone can see, it might be easier to determine that you don't have a minor injury. If you have post-traumatic stress disorder, you're being subjected to this extra level of a whole other in-person examination before you even get to see someone who will treat you, and you have to expose all your traumatic memories to this person. It's really not good for the patients.

Ms. Laurie Scott: No. So would you—we as a party are trying to present some alternatives to the auto insurance industry, but would independent peer-to-peer assessments help alleviate the number of assessments that occur, do you think? You're a professional in the business.

Dr. Amber Smith: I'd want to know more about what you're proposing. It sounds like it could. One of the things that our members from the field indicated is that paper reviews have all but disappeared, and it does seem like—you know, the example I gave of a physician in our community who diagnosed PTSD, referred to our clinic, and our screening suggested indicators of PTSD. It seems that if one of my colleagues was able to review that paperwork indicating that, then it should be fundable, that we should be able to assess that person properly, as opposed to having them go to an in-person assessment, and the higher burden and higher costs associated with that transaction.

Ms. Laurie Scott: Okay. That's, I think, what we're proposing, roughly, without—

Dr. Amber Smith: A paper review, a peer review sort of thing, yes.

Ms. Laurie Scott: Yes, so you don't have to waste time and find other people and—

Dr. Amber Smith: Right, or maybe an in-house consultant, something like that.

Ms. Laurie Scott: Definitely something needs to change. Do you think we're all talking about 1% of the population that fit into this, or—

Dr. Amber Smith: Well, we only see 2% to 4% of all injured people.

Ms. Laurie Scott: Okay. What else do you think would speed this process up, so that people get assessed more quickly but also get treated more quickly, as opposed to being caught in this mess of mediation?

Dr. Amber Smith: I think there really ought to be a way to be able to say that if you're following the standards that are set in our assessment and treatment guidelines, and you have the screening indicators, which, again, are in the guidelines, that even if you want to subject it to a peer review, a paper review, that really ought to be good enough. The patient shouldn't have to prove themselves and expose themselves in that way and create that higher level of burden and disability. I think more paper reviews—if people, again, are following the method—should be reasonable.

Ms. Laurie Scott: Okay.

Dr. Faith Kaplan: I had one thought, just in response to that: We do have a number of different weights on our system. To the extent that the anti-fraud measures give everybody a higher level of comfort that we are dealing with legitimate providers and people who are legitimately injured, it may be that some of this atmosphere of generalized distress drops away—

Dr. Amber Smith: That would be nice.

Dr. Faith Kaplan: —and that those who are legitimate providers and genuinely injured folks will be able to move forward in a more positive, constructive, collaborative way if we have more targeted approaches to fraud.

Dr. Amber Smith: Yes.

Dr. Faith Kaplan: So we're very, very supportive of the anti-fraud measures, and think that rather than trying to stifle everybody, if we can focus very vigorously on those that are committing fraud, it may free up and encourage a greater kind of collaboration on the other side.

Ms. Laurie Scott: Okay. I agree.

Mr. Jim McDonell: Just a small one: We seem to have two levels, and a lot of your energy is going into proving—not that they're not needing attention, but that they actually got hurt in the accident. And these are—

Dr. Amber Smith: I'm sorry, I can't hear you completely.

Mr. Jim McDonell: Oh, I'm sorry. Part of what you're trying to do here is prove that somebody was—not that they need some psychiatric help, but the fact that they actually got hurt in an accident which caused the requirement for the help. I would take it that these are illnesses that require—no matter where you get hurt, they need attention. So it seems like our health care system is failing us by not really treating people where it is actually confirmed that they need help. We're spending time trying to figure out whether they got hurt, and whether or not the health system would pay for it. Is that right? And really, the question should be: If they need help, they need help, period.

Dr. Amber Smith: Right now, unfortunately, for mental health we don't have a very cohesive system anywhere at all. Auto is only one example of where people with mental health problems aren't being picked up.

Mr. Jim McDonell: So overall—

The Acting Chair (Mr. Rick Bartolucci): Thanks very much. We'll go over to the NDP. Teresa?

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Ms. Teresa J. Armstrong: I have a question with regard to the mental health piece that we're talking about right now. You talked about that someone can have mental health as a result of an accident and develop post-traumatic stress disorder, or that people have a pre-existing mental health and that could escalate it further.

Dr. Amber Smith: Yes.

Ms. Teresa J. Armstrong: How does the pre-existing mental health piece fit into the new catastrophic definition? Is it taken into consideration at all?

Dr. Amber Smith: I do assessment and treatment. I will defer—do you want to answer that? I will defer to my disability assessor colleague for that.

Dr. Brian Levitt: It's a great question. You're asking basically about causation, so if there are pre-existing issues, how do we look at that in catastrophic? That's actually part of what's considered in the AMA guides, that we're supposed to look at a history; we're supposed to look at the impact of an accident. As long as the accident plays a significant role, the way the catastrophic impairment has been discussed, the way we look at it, we go ahead and we make a determination with respect to catastrophic as long as the accident plays a significant enough role. Someone may have a pre-accident vulnerability; the issue is, if the accident hadn't happened, would they be where they are now? Does that answer your question?

Ms. Teresa J. Armstrong: Yes, thank you.

Mr. Jagmeet Singh: So, just to understand—you can stay there too. The microphone will work there, yes. You can all just stay there together.

Dr. Amber Smith: Actually, it's the same criteria that has to be used even when proposing the most basic assessment or treatment plan. I don't want to speak on catastrophic because I don't do it, but the criteria for any access to any benefit under auto is that.

Mr. Jagmeet Singh: What I'm understanding from the overall—you've kind of painted a picture of what's going on in terms of pre-2010 and post-2010. Much the same way the NDP talks about a balanced approach to balancing the budget, I'm understanding now that we should also look at a balanced approach in dealing with

fraud as well so that it doesn't negatively impact those people who are being treated. One of the things I'm noticing, if I understand this trend, is that the approval rates for treatments are going down, the denial rates are going up, and the approval rates for partial approvals are going up. So people are getting partially approved at a higher rate but not fully approved. So what's basically going on is that if you look at the landscape of the treatment—and tell me if I'm understanding this right—the landscape of the treatment is that we're getting less full treatment plans and more denials, so people aren't getting the quality of treatment that they should be getting.

Dr. Amber Smith: Yes, that's true. Also, there's a pressure on proposing psychologists to propose shorter plans in hopes that they're more likely to be funded, because adjusters are also very aware of cost. So from the adjusters, the proposers, the IE assessors, everybody is kind of nickel-and-diming the care, and it ends up with this choppy, watered-down care. I really think everyone is trying their best. I'm only speaking about, of course, the most ethical providers. Everybody wants to do well. The adjusters I speak to want to fund legitimate treatment. The IE assessors are trying their best to look after—everyone wants the system to function for the patient, but we're ending up in this system where everything is partially approved and smaller and shorter. It makes it very difficult to have any momentum in rehabilitating someone.

Mr. Jagmeet Singh: So just as feedback—I mean, what you're doing is providing feedback so that on the ground level, in primary care and on the front lines of providing this care and treatment for people, this is what you're noticing, that the direction that we're headed in is this choppy and not full, expansive treatment. That's something we should keep in mind when we're moving forward with recommendations to improve the auto care system.

Dr. Amber Smith: And bear in mind, of course, we see this very small proportion of people. I don't know and can't speak to the 95% that we don't see. For these very injured, vulnerable people, this small percentage, that's what's happening, and it's not effective care for them.

Mr. Jagmeet Singh: Okay. Can you comment on just specifically—you talked on this briefly, but just maybe the MIGs and the impact on treatment in terms of psychological treatment, as well as the new cap; before it was $100,000 and now it's reduced to $50,000. What has been your experience with the impact on treatment for the patients that you deal with?

Dr. Amber Smith: For the minor injury cap, what we're seeing is that it seems to be holding in plenty of people. There are some questions about how to determine who's in and who's out. So many of our colleagues are getting those assessments to determine whether someone has a psychological condition that should take them out of the minor injury cap or not. We had been seeing some terrible misapplications of that minor injury cap for people with frank brain injuries and post-traumatic stress disorder. I've been seeing a little less of that over the past year; most of our colleagues who are doing the IE work are obviously taking people out of the minor injury cap.

The concern is really the process the patient has to engage in when it really is quite obvious that they were misplaced and didn't have minor injuries. They shouldn't have to go through this big—sometimes it's multiple IEs for every injury that they've sustained, so they have to see a physical assessor, an OT; it's like a catastrophic assessment for minor injury determination.

The $100,000, the reduction—well, patients are running out. Our patients are running out; they just are. They're running out.

Mr. Jagmeet Singh: Okay. And just let's touch on this idea that there are some folks, maybe a majority of folks, who are placed into the MIG, the minor injury guideline, that may be appropriately placed there, but for the folks that aren't supposed to be there, the process to get out of there, I guess, to put it that way, is very onerous and very difficult. Your feedback is that there needs to be a better mechanism for the small percentage of folks that maybe are misappropriately put into that category. For them to get out of it, there have to be some easier steps, because otherwise it's very difficult. Is that what I'm understanding?

Dr. Amber Smith: Yes, and I have to think it's awfully costly when it goes through three IE assessments just to get up to the $50,000 level and the indicators are all right there.

Mr. Jagmeet Singh: Okay. And just with the IE issue, the independent examination, my colleague brought up a good point. I think it's a good system, but one of the proposals has been that peer-to-peer reviews of—

The Acting Chair (Mr. Rick Bartolucci): Two minutes, Jagmeet.

Mr. Jagmeet Singh: Sure. So maybe I'll just ask, instead of putting my opinion forward: What are some concrete ways that we can—do you see problems with the independent examiners, the system that currently exists, and what are some suggestions to make it better?

Dr. Amber Smith: There's an awful lot of variability, and one of the things OPA and CAPDA are doing is to develop joint guidelines, again, on assessment methods so that we have an agreed-upon set of methods that will clear that up.

Mr. Jagmeet Singh: Okay. And what about the idea of having actual practitioners, people who are actually treating psychologists, be involved in the independent examinations, as opposed to strictly examiners?

Dr. Amber Smith: Yes.

Mr. Jagmeet Singh: That's what I think as well. All right.

The Acting Chair (Mr. Rick Bartolucci): Thank you very much. Mike?

Mr. Mike Colle: Just briefly, who pays you?

Dr. Amber Smith: Oh. Who pays me to do—

Mr. Mike Colle: Do your work.

Dr. Amber Smith: To do the assessment and treatment? Various insurance providers. In this case, we're talking about the auto patients: auto insurers.

Mr. Mike Colle: Yes. So that's part of a private health care system.

Dr. Amber Smith: Yes. I manage a busy private clinic, and so we see—it's a bit like American health care. We see WSIB, auto, veterans, private, out-of-pocket.

Mr. Mike Colle: So how many millions of dollars a year do insurance companies pay out to private health care for people that have psychological impairments? Do you have any idea?

Dr. Faith Kaplan: I think there's a bit of subtlety when you say, "Who pays us?" though, just to step back a bit. It's actually the insured person's benefits.

Dr. Amber Smith: Yes.

Dr. Faith Kaplan: And the insured person then seeks treatment. A proposal is developed. If they consent to it, it then goes to their insurer to see if the insurer will agree to give them the funding to pay for those services.

Mr. Mike Colle: But the insurance company cuts you a cheque.

Dr. Amber Smith: If the insured person requests it. The insured person has to come to us and request to use their accident benefits in this way.

Dr. Faith Kaplan: When we last saw about amounts of costs that were going to psychological services, and this is off the top of my head and I will look it up and get it for you, I think it was around between 2% and 4% of the amount spent overall on ABs that went to psychological services.

Mr. Mike Colle: It's a small portion, yes. If research can get the various costs of this private health care system that includes all private health care providers that are under the umbrella of insurance.

Also, you made a point here about the fact that, as insurance-funded services shrink, the hospital wait-lists grow and the ER visits increase. How do you quantify that, or where are you getting that information?

Dr. Amber Smith: That was a quote from a hospital psychologist in London.

Mr. Mike Colle: That was a hospital psychologist in London who said that. Could you give us his name?

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Dr. Amber Smith: I will ask.

Mr. Mike Colle: If you could forward that, please.

Dr. Amber Smith: Okay.

Mr. Mike Colle: What's the difference between the Canadian Academy of Psychologists in Disability Assessment and the Ontario Psychological Association? Are you in—I'm not quite sure—CAPDA and—

Dr. Amber Smith: OPA. CAPDA is a federal organization, and it focuses on assessment of disability. We're a provincial organization and we cover the gamut. We do assessment and treatment. The disability assessors don't necessarily do assessment and treatment.

Mr. Mike Colle: So they just do assessments?

Dr. Faith Kaplan: Some of the members do treatment.

Dr. Amber Smith: Some of the members do treatment, but the organization is about disability—

Interjection.

Dr. Amber Smith: Yes. The organization is about assessment.

Mr. Mike Colle: They do assessments and you do everything. Like, you do the treatments?

Dr. Amber Smith: Well, some of our—we can have some of the same membership, but that organization is about doing disability assessments. Ours is a fraternal organization, open to all psychologists.

Dr. Faith Kaplan: And many of the psychologists in the Ontario Psychological Association are not involved in the auto sector. Many are in education, corrections, industrial psychology. A wide range of roles that psychologists have in our communities are all part of that one fraternal organization.

Mr. Mike Colle: And what do you get paid per assessment by the insurance company?

Dr. Amber Smith: Which kind of assessment? There are many different—

Mr. Mike Colle: When you're trying to assess a patient to see if they are basically injured—

Dr. Amber Smith: Every assessment under auto insurance is capped at $2,000, and we also have—

Mr. Mike Colle: So for every assessment done, a psychologist would get $2,000?

Dr. Faith Kaplan: No. There is something called a professional services guideline that sets an hourly fee for psychologists, as well as for other health professionals. In addition to the professional services guideline, an assessment fee cap was introduced in the more recent regulations.

What we have are assessment and treatment guidelines, and I'd be very happy to share them with you, that outline—answering your question about what are the different tasks you need to do when you're undertaking an assessment—and, in outlining those tasks, talk about reasonable ranges of time that are required to do each of those tasks. Then, depending on how much time you need and that professional hourly fee—

Dr. Amber Smith: And how complicated the patient is.

Dr. Faith Kaplan: —you get a number of hours. And then even if it's going to take, say, 16 hours, you still cannot charge that full amount, because there's a cap that limits it.

For a number of patients—say where we were talking about the pre-existing factors—that's where those assessments are likely to be more complicated and take longer to do.

Mr. Mike Colle: Who pays for those assessments?

Dr. Faith Kaplan: Again, the services are paid for when they're approved, and only approved services are paid by the insurer.

Mr. Mike Colle: The insurer pays for the assessments, and then that patient—do they get any assessment

from the public health sector, or is it just the private health sector?

Dr. Faith Kaplan: Again, many of the patients who are being referred to us by their family doctors are patients for whom there are not timely services available through the public health sector, and that's why they're being referred to us.

Mr. Mike Colle: Do they get any assessments from the public health provider?

The Acting Chair (Mr. Rick Bartolucci): Two minutes, Mike.

Dr. Amber Smith: That's very difficult to answer. There aren't very many services available in the public system.

Mr. Mike Colle: So the only service really available to people in auto insurance is private health care. Right?

Dr. Amber Smith: It's not the only. It's very fractured.

Dr. Faith Kaplan: But some of our patients, say, may be seeing—in Hamilton, there are these family health teams, many of whom will have a social worker or a psychosocial counsellor as part of their staffing. We find it very interesting that many of our patients will have seen one of those counsellors as sort of the first resort that the family physician—

Mr. Mike Colle: But they don't get paid by the insurance company?

Dr. Faith Kaplan: No.

Mr. Mike Colle: Okay.

Dr. Faith Kaplan: And when that counsellor feels that there's something more significant that requires more specialized care, they will refer them.

Dr. Amber Smith: Then they refer to us.

Dr. Faith Kaplan: That's one example where somebody will have gotten some services first that were not paid by the auto insurer.

Mr. Mike Colle: Yes, okay. Thank you. But just to make sure, what I was asking for is the cost of this private health care system that we have here in Ontario and the scope of it—

The Acting Chair (Mr. Rick Bartolucci): He made a note of it already.

Mr. Andrew McNaught: So you want it broken down by specialty—

Interjections.

Mr. Mike Colle: I know it's going to be difficult, because they gave a helpful percentage, but just to—I don't know where we get that, from the insurance companies or whatever, just to see what the cost of this private health care system is in Ontario.

The Acting Chair (Mr. Rick Bartolucci): Great. Thanks very much.

Dr. Faith Kaplan: I guess part of what we're discussing really is, where do no-fault benefits for medical and rehabilitation fit into our overall health care system?

Mr. Mike Colle: Yes. I just think most people don't realize we have two health systems here in Ontario, and especially, very accentuated, in the auto sector. They think it's a public health care system, but when it comes to auto, there's a mammoth private health care system.

The Acting Chair (Mr. Rick Bartolucci): Ms. Kaplan, Ms. Smith, thank you very much. Your time is up.

Dr. Faith Kaplan: Could I just add one detail to that public-private mix?

The Acting Chair (Mr. Rick Bartolucci): Sure.

Dr. Faith Kaplan: It's even a bit more complicated, because people often have private extended health care benefits.

Dr. Amber Smith: Actually, they have to be accessed first.

Dr. Faith Kaplan: Separate from auto, right. And so, if we're seeing somebody, the first payer we bill is their private extended health benefits—

Dr. Amber Smith: That has to be exhausted.

Mr. Mike Colle: Before—

Dr. Faith Kaplan: Before auto.

The Acting Chair (Mr. Rick Bartolucci): Great. Thank you very much for the presentation and for the clarification. Thank you.

EXPERT PANEL, ONTARIO REHAB ALLIANCE

The Acting Chair (Mr. Rick Bartolucci): All right. Our last group is the expert panel of the Ontario Rehab Alliance. We welcome Patricia Howell, Rhona Feldt-Stein and Tracy Milner.

Patricia, are you doing the presentation? Okay. Welcome.

Ms. Patricia Howell: Good afternoon.

The Acting Chair (Mr. Rick Bartolucci): Good afternoon. Go ahead.

Ms. Patricia Howell: My name is Patricia Howell and I am here with Rhona Feldt-Stein and Tracy Milner. We are therapists with extensive experience working with auto insurance victims. We are here today representing a 25-member panel comprised of experts in the fields of rehabilitation, neurology, psychiatry and neuropsychology, clinicians from both the public and the private sectors, and not-for-profit groups that support accident victims across Ontario.

In 2011, our group prepared a detailed, evidence-based analysis of the FSCO cat panel report. We agreed that the catastrophic definition could be improved in some areas; however, the definition proposed by the FSCO expert panel had serious flaws: scientifically, clinically and practically. Our group worked diligently to propose evidence-based revisions that would help resolve these issues. When the superintendent's report was released, we were dismayed to see that our feedback was largely ignored, and new barriers to care were added. During these hearings and at the multi-stakeholder round table that was recently held, groups representing accident victims and the clinicians who work with them have been speaking out with one voice against these changes.

We were so pleased to hear in last week's budget announcement that the government is proposing that a committee take time for further study and consultation on the cat definition before any changes are made, as well as a committee to look at the impact of the reforms so far. The Ontario Rehab Alliance and our expert panel are committed to being part of this process.

We appreciate this opportunity today to briefly outline our concerns with the proposed cat changes. We will also present some new data that demonstrates the devastating impact the September 2010 cuts have had on the estimated 12,000 Ontarians who sustain a serious non-cat injury every year.

Ms. Rhona Feldt-Stein: Our concerns with the cat changes fall into three areas: the process, the specific criteria proposed, and the impacts these changes have on the most seriously injured.

Regarding the process, six out of eight members of the FSCO panel are academics and researchers with little to no clinical experience with auto insurance victims, and are therefore not able to connect to the real-world implications of their recommendations. Half have been consultants to IBC, introducing potential bias. In addition, they used the Delphi method to develop consensus, a method which was previously discussed today.

Our second concern relates to the specific changes proposed. We do not support removing well-validated and widely used assessment tools such as the GCS before the new tools have been proven clinically relevant, valid and reliable—

The Acting Chair (Mr. Rick Bartolucci): Excuse me just for a second. Sorry to break it up, but for Hansard purposes, could you identify yourself?

Ms. Rhona Feldt-Stein: Okay, sorry. I'm Rhona Feldt-Stein.

The Acting Chair (Mr. Rick Bartolucci): Thank you so much.

Ms. Rhona Feldt-Stein: You're welcome—as well as disallowing the combination of mental and physical impairments.

We do not support arbitrarily setting thresholds that are far too difficult to reach, especially given that there is no evidence to indicate that the estimated 1% of victims who are deemed catastrophic under the current definition are accessing benefits inappropriately. It is very important to understand that even if deemed cat, claimants only receive services and supports if they are proven to be reasonable and necessary.

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We do not support setting thresholds that are not consistent for all disability groups. For example, under the proposed definition, people with a single limb amputation or paraplegia would be deemed cat, but those with psychiatric conditions or brain injuries who are dependent on others, unable to work or go to school, and have devastating social and behavioural problems would not qualify.

We do not support introducing criteria that are discriminatory based upon age or where someone lives. For example, in the proposed definition, a child with a brain injury who happens to live near one of the five level-1 trauma centres in Ontario could be deemed cat, based on positive imaging, while another child with the same imaging who happens to be seen in another hospital would not qualify.

We also do not support mandating that family doctors sign treatment plans where evidence shows that they lack the qualifications and time to do this, especially given that the trend is to download responsibilities from our overworked family doctors, not the other way around. For victims who have a family doctor, they would have to see their doctor about every two weeks, which we know is not reasonable. For the 600,000 who do not have a family doctor, that means no access to care.

If proposed changes are implemented as recommended, it is estimated that the number of people deemed cat would be cut in half. The following are some examples of people who would no longer qualify:

—the bright child who is gifted in sports and music, who sustains a serious brain injury, who after six months still needs help with her basic self-care for dressing and feeding, and who, by one year, although able to return to school, is unable to focus, remember or learn in class, and, due to regular behavioural outbursts, has lost all of her friends and cannot participate in individual, let alone team, sports; and

—the accountant who is in coma for several weeks, by six months still has excruciating headaches, weakness and incoordination, and who has such significant cognitive problems that he needs an attendant in the home every day, and by one year is only able to attempt working in a sheltered workshop, supervised, perhaps doing assembly line work, and only part-time.

Ms. Tracy Milner: I'm Tracy Milner, and we'd like to now discuss the impact of the 2010 reforms on those with serious non-catastrophic injuries.

The insurance industry's rationale for the cuts of the serious non-catastrophic benefits in 2010 was that costs were skyrocketing because of the widespread abuse and fraud across all injury groups. We now know that fraud happens primarily in the minor-injury group and is more criminal than opportunistic in nature. These issues are being well addressed with the introduction of the minor injury guideline and the activities of the anti-fraud task force, while now insurers are now experiencing record profitability.

Indeed, those with serious non-catastrophic injuries were innocent victims of the war on fraud. A survey of Ontario's health care providers to be released by the Ontario Rehab Alliance this week reveals the devastating impact of the 2010 cuts. The survey found that only 17% of the serious non-catastrophic victims are currently attaining their rehabilitation goals before their funding runs out, as compared to 57% prior to September 2010.

As these funds are depleted for non-catastrophic victims before they are better, their providers are referring them to the public system in record numbers, up from 15% to 62%. Without rehabilitation, these individ-

uals no longer have a chance to return to productive work or school, and will likely go on to secondary mental health complications and become a burden on the health care and social system. The long-term cost to society far outweighs the initial cost of what the rehabilitation would have been.

It is noted that the FSCO expert panel did recognize that those that would eventually be deemed catastrophic would go on waiting for years prior to their designation, and they proposed an interim catastrophic category. However, this would only add more complexity, costs and delays to the system. Instead, we recommend that we need to raise the serious non-catastrophic benefits back up to an appropriate level.

Ms. Patricia Howell: In summary, we are advocating for the following: that the proposed changes to the cat definition not be implemented at this time; that the serious non-cat benefits be returned to the pre-September 2010 levels; and that a multi-stakeholder committee should be struck, with at least a two-year mandate, to provide comprehensive and sound recommendations regarding both cat and non-cat categories. Given how much more complex these injuries are, as compared to the MIG, for which the committee was given two years to come up with the recommendations, we also recommend separate subcommittees of experts for each impairment area—for example, one subcommittee with expertise in traumatic brain injury, another one for spinal cord—just because, really, they're such specialized fields. If you want to use the Delphi method, you need a consistent, homogeneous type of group, and we found that that worked well with our panel.

Thank you.

The Acting Chair (Mr. Rick Bartolucci): Thanks very much for your great presentation. We'll start off now with the NDP. Jagmeet?

Mr. Jagmeet Singh: Sure. Thank you so much. Thank you very much for attending today and presenting. To begin, can you comment on this suggestion that with the current changes to the care provided, or the coverage that consumers get, in the auto insurance package, there's going to be a shift now from the insurance companies paying for this treatment, and the burden's going to shift from that care to the public, and there will be an increased burden or strain on an already burdened public system, with respect to some of these folks who aren't going to be covered. Can you respond to that? Do you agree with this comment, and what's your response?

Ms. Patricia Howell: I can respond on that. Our survey found that, basically, if you look at the clients coming to us, if the funds run out in six months to a year, and it's a child with a brain injury, in the past our data is showing that almost all of those are very severely disabled still at the end, when the funds have run out. Our data is showing—and we're not really surprised—that people are trying to get them help, so they're referring them back into the public system. The problem is getting help. There aren't a lot of services out there, so that's another issue.

Certainly, I think when the data comes out—this is a survey of our members. We have providers across Ontario; 85 of our member companies—we had about 130 responses, and they were saying that 62% of individuals were referred back into the public system. I'm sure that when we see public funding numbers coming out, we're going to be seeing wait-lists going up etc. in the public system.

Mr. Jagmeet Singh: So that covers that shift to the public system. It's already burdened, and there will be increased wait-lists and increased issues.

Ms. Patricia Howell: And it basically can't absorb them; that's the problem. There aren't services out there for them.

Ms. Tracy Milner: And I'll just add that when you shift care to a system that was perhaps unprepared to take on this care, and you have wait-lists, then you're going to have patients who are not receiving treatment. What we know, as health providers, is that the severity and the refractory nature of the disability become much more difficult to treat the longer that you wait. Early intervention is key to minimize disability.

Mr. Jagmeet Singh: So if I understand what you're saying, if we don't treat these illnesses or these injuries early on, they can actually result in higher costs down the road, because the illness itself can get worse, or the injury itself will get worse, and it actually would cost more to treat it or to deal with it in the long run, then.

Ms. Tracy Milner: And not just whatever the initial injury was itself, but also all the secondary complications that come from inability to work and the mental health issues that arise from that.

Mr. Jagmeet Singh: So you've touched on this, but perhaps you could tell me the impact to folks who have been deemed to fall within the minor injury guideline. As front-line care providers, what has been your experience, what have you seen and how is that impacting folks who are being put into this category? What's your feedback on that?

Ms. Tracy Milner: I would say that primarily our practice works with people who have been most seriously injured. What has been surprising to us, even in our space and the types of people that we treat, is that a number of them with brain injuries or fractures are still being captured by or being told to go through the minor injury guideline. I believe the Auditor General's report, when it was released, had indicated that the minor injury guideline was actually capturing 80% of people in it, and later on in the report it said that 60% of claimants had mild injuries. So that was a bit confusing to me, in terms of looking at what that gap was, and perhaps an over-capturing of what the actual needs were.

Mr. Jagmeet Singh: So one of the suggestions that has come up, kind of in line with what you've just said, is that if the vast majority of people are being funnelled into the minor injury guideline—and perhaps many of them are fairly in that category—

Ms. Tracy Milner: And appropriately, yes.

Mr. Jagmeet Singh: —appropriately in that category—for the small percentage of folks who are not, or

who are inappropriately put into that category, there should be some mechanism for them to appeal that decision to get out of that category and get the proper care that they do require. For that small percentage of folks, do you agree with that, that there should be a mechanism?

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Ms. Tracy Milner: Absolutely, and the key is quickly, because we know that, again, we're promoting or we're exacerbating disability the longer we wait.

Mr. Jagmeet Singh: Okay. Turning to the proposed catastrophic injury changes, you've talked about some of the concerns and some of the issues and what changes you do support and you don't support. One suggestion that has come up a couple of times, and you might have heard about it today, is that instead of revisiting the definition of what is catastrophic impairment, instead of revisiting the actual definition, put more emphasis on the actual methods or methodology to reach a conclusion—that that would result in more reliable results. Do you support that assertion or that idea?

Ms. Rhona Feldt-Stein: Yes.

Ms. Patricia Howell: I think our expert panel, when we look at the—when the FSCO panel first came out, we were only given three or four weeks. If you imagine top neuropsychologists together, physiatrists, these are very difficult people to get time with. We had their input and we did do a consultation. We looked at each of the tests that were looked at and we suggested which tests needed to be validated. They weren't a valid test. You can't possibly suggest replacing the current test with a test that hasn't been proven to be a valid and reliable tool. For example, the KOSCHI, which is the tool they were using for children with brain injury, they've revised the actual cut-off point. They made up a new definition. They clearly said that this test needs to be revalidated. That's kind of the approach we took.

Where I think this discussion around the methodology has come up is largely around the combining of the mental and physical. What's coming out, especially from psychologists and physiatrists who are doing those assessments, is that there's really no clear methodology being used out there by assessors since the DAC.

So I think they go together. They're two points. There might be new tools that might be good, promising new tools, but you shouldn't take the ones that we're using away until they're proven valid. Even practical tools: Some of the tools they recommended are more designed for a hospital setting. They're not really to look at function in the community—or they're not available, that no one is doing those tests or no one knows how to do those tests.

So I think, really, all of those fit together is why we're recommending you take a step back and get experts together to really take a systemic look at what changes should happen.

The Acting Chair (Mr. Rick Bartolucci): Two minutes, Jagmeet.

Mr. Jagmeet Singh: Okay. I'm going to rattle off a couple of quick points, and maybe you can give me some support on that or disagreement if you don't.

One of the issues with the expert panel has been the Delphi method and the way it was set up, based on the number of people on that expert panel as well as the specific type of people in terms of their specialties. Specifically, what I'm talking about is the fact that there's only one psychologist expert on the panel, that the Delphi method used would basically marginalize that individual's opinion, and there could be a consensus decision without having any input from the one psychologist on the panel. That was a severe problem with the expert panel. Do you agree with that?

Interjection: Absolutely.

Ms. Rhona Feldt-Stein: There was also only one pediatrician on the panel.

Mr. Jagmeet Singh: So again, when it comes to young people and young people's issues, they would also be disproportionally marginalized or silenced, given that method and given the fact that there was only one person on the panel.

Ms. Patricia Howell: Yes.

Mr. Jagmeet Singh: Okay. With respect to the idea that there's already a small percentage of people who are captured by the catastrophic definition: There is no suggestion or proof or evidence that there is a significant need to reduce the population of people who are captured. There's already so few people captured that further reducing that—there's no, I guess, empirical data to support that. Do you agree with that suggestion?

Ms. Patricia Howell: Yes.

Ms. Tracy Milner: I can't underscore enough, when you say that 1% is the number of people being captured as catastrophic, that we're already doing a good job figuring out who is the most vulnerable and severely injured.

Mr. Jagmeet Singh: Fair point. That's good.

The Acting Chair (Mr. Rick Bartolucci): Great. Thank you very much. We'll move to the Liberals. Anybody?

Mr. Bas Balkissoon: Thank you very much for being here. I just want to go back: If I heard what you were saying, the current definition, you would not use it but go back to what was there before 2010?

Ms. Patricia Howell: No. There are two steps. In September 2010, they revised the benefit package for this year's non-cat, and they cut it from $100,000 in med rehab plus assessment costs, which we know can be expensive because it's a medico-legal system. They also cut—they made other changes, caregiving etc., so that that's not available.

That's what we're disagreeing with, and we're saying that is the larger group. About 10% to 20% of injuries fall into that serious non-cat. Before September 2010, that $100,000 used to last about two years. It depends on the severity of the injury, but on average, someone with, say, a brain injury, it would last about two years. At about the two-year mark, they can start to do a cat

assessment and then it can take sometimes another two or three or four years till that goes through the whole system of courts and someone is finally deemed cat. So even before, there was a gap till you got that $1 million and you could get back into rehab again.

What we're finding now, since September 2010, with $50,000, clients are running out as early as six months. So if you think of working with a teenager with a head injury and you're trying to get them back to school, you've just got them back—they might have started one day a week and been gradually working to go longer, and what's happened is that when they're just sort of in the prime part of their rehab, they're running out of funds. That's the September 2010 piece that we're saying we really should—we are so glad to see the government now wanting to look at the impact of those reforms.

I think we all understand now that that was kind of a blanket cut to everybody across the board just to save money at the time, because costs were escalating. I think now people are kind of realizing that fraud isn't really a broad thing that's happening across all—everyone's trying to take advantage. They're now realizing that there are some criminals out there and we need to go after them; and also, that the fake injuries tend to be not so much—people don't fake brain injury; it's very hard to do. They can fake other areas. It's more in the minor injuries that get exaggerated, so we're asking that we revisit those cuts to the $50,000.

The second piece is the proposed new definition that was proposed just last year by the FSCO panel, and that we're disagreeing with.

Mr. Bas Balkissoon: How do you suggest we go about finding the new definition?

Ms. Patricia Howell: How do we—I'm sorry? Can you repeat your question?

Mr. Bas Balkissoon: Would you recommend a process towards getting to that new definition? Because most of you expressed dissatisfaction with the expert panel and what they arrived at. What would be a method that the government can use?

Ms. Tracy Milner: I think there are two pieces here. One is, do we need to alter the definition at all, given we're already capturing that 1% of people, and knowing that there's a second-tier system already in place that looks at whether or not it's reasonable or necessary for them to have the benefits to which they have access?

The second piece is that if we are going to look at the definition, then it needs to be a multidisciplinary, collaborative, well-founded scientific approach to looking at what the definition is. It looks at impairment but also at what the functional impact is for those people and who requires the most treatment and how. That's going to require more people, more time, and the right people.

Mr. Bas Balkissoon: Do you believe that if we improve the assessment process for the further services that some of these people need that it will help some of them? Because I understand from some people that the assessment process to go beyond the $50,000 has been delayed; it's jammed up with the arbitrators. If that process was focused on improving it, would it benefit some of your patients?

Ms. Patricia Howell: Yes. I think there are two things happening. One, there aren't enough funds, so even if we've got a wonderful adjuster who—and many adjusters have more experience and they understand the conditions and they're easier to work with. Others have no experience at all in that category and they don't understand and they deny everything. So one factor is having enough. Even if we have the most supportive adjuster, who is approving treatment appropriately, we're still running out of funds too soon. So there are two pieces.

Other adjusters, even with $50,000, it's constantly starting and stopping, because they're denying and you have to stop until the IE's done and you have to wait two months. So you've been working with someone for two months, your next treatment plan is rejected, you've got to wait for the IE to come in. They don't get any help for another two months, they've regressed and you're going back in. There are constant stops and starts, and that's just not good rehab.

Mr. Bas Balkissoon: Okay. Thank you.

The Acting Chair (Mr. Rick Bartolucci): Thanks very much, Bas. We'll move to the Progressive Conservatives. Laurie?

Ms. Laurie Scott: Thank you very much for appearing. I think you've been appearing before. I'm getting to see some familiar faces.

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Just to follow up on Mr. Balkissoon's comments, is there a jurisdiction that actually provides either a definition or some type of similar category for catastrophic injuries, other provinces, areas in the States, that do a better job of treating so-called catastrophic injuries? It's okay if you don't know one, but I just thought I'd ask, since we're having all these discussions.

Ms. Tracy Milner: I mean, certainly, the AMA guide—

Ms. Laurie Scott: The American Medical Association.

Ms. Tracy Milner: Exactly—is used in the United States and in other places and so forth. I think with any system, there's always the challenges and the benefits to it, so if you're looking at what the system needs to be going forward, then I think it's about looking at it collaboratively now, based on the best information that we have to date.

Ms. Laurie Scott: So you're happy that they're going to have a relook at the "catastrophic" definition that was proposed. What happens to the people that are stuck in this grey area right now since 2010 until we're relooking at the catastrophic definition? Do you have some guidance? Because I have heard these stories continuously, and it is not correct, the treatment they're getting. How do we help those people who are in that grey area till we sort out a better catastrophic definition?

Ms. Tracy Milner: Well—

Ms. Laurie Scott: Or methodology. It doesn't have to be a definition.

Ms. Rhona Feldt-Stein: I think, first of all, we have to look at—you know, they need more money. I'll give you an example of a young child who was catastrophically hurt in a car accident at the age of six weeks, and their difficulties didn't start showing until he was three years, but by the time he was four, when a lot of his academic skills and development was just progressing, he ran out of money. And we knew that this child was potentially going to be catastrophic, but where his GCS, where the cut-off was, was just a hair on one side or the other, and he ran out of money at four years of age.

Ms. Patricia Howell: And that was when there was $100,000 plus assessment costs, so we're just seeing this happening across the board now. I mean, there are some individuals who have injuries where $50,000 or $100,000 is enough. There are just so many that are not.

Ms. Laurie Scott: I'm going to hand you over to our insurance guru here.

Mr. Jeff Yurek: I'm not a guru yet. I've got about 24 years more to go.

Anyway, my question, this change to the cat definition—I do have some questions and problems with the proposed changes that I'd like to see fixed before the government brings it out. Because I think you're right: There are going to be a lot of problems in the system—there already are a lot of problems in the system. Because the main thing—I think the catastrophic definition and the rest of the insurance product should be developing treatment to the victims of accidents and making sure—

Ms. Patricia Howell: I'm sorry, I'm having a bit of trouble hearing you.

Mr. Jeff Yurek: I'm sorry. Last time I was here, they make me move the mike because I was just shouting.

The product itself should be looking after those injured in the accidents. That's what its primary focus should be, and we need to ensure that any changes don't further deteriorate the product, but at the same time also try to make it an affordable product so that people actually buy it and are not without insurance at all.

For rural Ontario in particular, mandating that doctors sign treatment plans—and maybe you can talk about this—there's a whole section of the western side of my riding which had lost three or four family doctors. People don't have a family doctor, and the family doctor who is working has 3,100, 3,500 different patients. Do you not think that's going to burden the system and make treatment plans longer, let alone find a doctor to sign off on it? Or do you think there are other avenues we could take?

Ms. Patricia Howell: The issue of having family doctors as gatekeepers came up when they were looking at the 2010 cuts, and it was discussed at length and it was removed. The FSCO panel, the expert panel, did not recommend it. The only person that put it back into the system was the superintendent. Our panel and the Ontario Rehab Alliance were really dismayed to see that, because not only did he suggest it for the interim cat, which is that amount of money that they were suggesting might be allocated to carry you to cat, he also suggested it should be for all catastrophic claims for the rest of their lives. That means that every time someone needs a new cane or they need occupational therapy or they need any service renewed—because we have to renew our plans every few months—you'd have to go and visit your family doctor and get the doctor to sign off. We estimated that that would represent about 12,000 family doctor visits a year. Taking it on a personal basis, an individual would probably have to go to see their doctor up to 30 times a year to get something signed. So, that's about every two weeks. There's no way that's practical.

The second piece is that we're seeing legislation introduced by this government to download responsibilities from family doctors—they are overworked—with pharmacists being able to inject etc. It's just against all of the trends in health care that a doctor has to oversee a physiotherapist prescribing a cane, for example. That's well within their practice.

The last piece is that family doctors get almost no training on rehabilitation during their medical training. They're trained on medical, not rehab. That's why there are specialists in rehabilitation medicine etc., that are the ones that we work with in terms of getting medical input with our clients. So, absolutely, we do not support it. We think it's just going to add a huge barrier to care to the very vulnerable, those that even are deemed catastrophic.

Mr. Jeff Yurek: It seems a step backwards considering nurses and pharmacists are getting an expanding scope of practice that maybe we should look at including other health care professionals, and that's good.

Ms. Patricia Howell: Yes.

Mr. Jeff Yurek: I have heard, and I don't know if you've heard anything on it, that some of the insurance companies are kind of not on board with the catastrophic change now that it has been changed by FSCO and changed from the original form. Have you heard any of that at all, thereabouts? No? Okay.

Ms. Patricia Howell: Do you mean, are they using the new definition?

Mr. Jeff Yurek: No, no, that they're not really favourable of the changes that occurred because it has been modified from the original document that was presented from committee.

Ms. Patricia Howell: No. I'm not aware.

Mr. Jeff Yurek: No? Okay.

The other question I also would like some comment on is the combination of mental and physical impairments. In my practice at the pharmacy I see quite a bit how—not including the mental aspect of injury—it can actually exclude people because the effects that that has on someone who has gone through a traumatic experience or let alone a brain injury of some sort, and it's hard to pinpoint and diagnose. Maybe you can just elaborate more on your thoughts.

Ms. Tracy Milner: I would say that the trend in health care—best practices, the World Health Organization and so forth—is to look at people holistically, and to look at the ability to separate cognition from emotional health from behaviour and from physical impairment;

they all intertwine. So to try and take this person and literally chop them up into pieces and say, "Well, no, let's look at each of these in isolation," really isn't what we see affects the person's ability to function. It really is the person's ability to function that has all of the effects on health care, on mental health, on whether they work, on whether they take care of their kids, whether they have functioning relationships, whether or not they're able to go to school and learn and so forth. It's only when you see that in a holistic, comprehensive view that you can actually understand how to treat. So, then, to separate it and say that it doesn't exist that way, that chronic pain doesn't affect it, that psychological, mental and behavioural can't be combined with physical, it just seems not evidence-based.

The Chair (Mr. Bas Balkissoon): Thank you very much. We're at the end of questioning—

Interjection: You've changed.

The Chair (Mr. Bas Balkissoon): Yes, we did.

Thank you very much for being here, and thanks a lot for your presentation.

COMMITTEE BUSINESS

The Chair (Mr. Bas Balkissoon): Members of the committee, before we adjourn there are a couple of business items I need to go through with the committee. We had requested, as a committee, for OSFI to be here, and GISA. Unfortunately, OSFI cannot be here at our next meeting but GISA can be. I know committee members said they wanted both organizations on the same date, so I'm in your hands—what would you like to do? Mr. Colle, I think this was your concern. Only one group has confirmed they can be here.

Mr. Mike Colle: It would be helpful. I mean, this is going to go on for quite a while, so there's no hurry. When they can both be here, get them both here. I think it's helpful. Mr. Yurek, I think, mentioned that they wanted OSFI here too. I don't think there's a time frame here, right?

The Chair (Mr. Bas Balkissoon): Okay, so those were the only two groups we have, and we have a third person asking to attend committee. So, then, our next meeting will just be the third person, and we would have to contact them. Mr. Singh?

Mr. Jagmeet Singh: My suggestion to the committee, depending on everyone's input on this, is that if we have GISA confirmed for sure, we might as well get the person confirmed and nail them down tomorrow—not literally; figuratively. We can hear from them tomorrow, and then, whenever OFSI is available, we'll hear from them as well.

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I'm just concerned that if we have to wait for both of them to be available on the same date, it might put it off to sometime very far in the future. If we have somebody confirmed for sure tomorrow or on Wednesday, we might as well hear from them and then, certainly, make time for the other folks. That's just my suggestion; I think that makes the most sense.

The Chair (Mr. Bas Balkissoon): Mr. Yurek, you have some input?

Mr. Jeff Yurek: Since you asked, yes. I appreciate where Mr. Singh is coming from, but I think you get a better bang for your buck if you have both GISA and OFSI on the same day, so that we can use one off the other—whichever one goes in order, but—

The Chair (Mr. Bas Balkissoon): Okay.

Mr. Mike Colle: We'll have a—what do you call those? One of those runoffs, or head-to-head—

Mr. Jeff Yurek: Yes, head-to-head.

The Chair (Mr. Bas Balkissoon): Then on May 8—

Mr. Jeff Yurek: Do they have a date when they can come?

The Chair (Mr. Bas Balkissoon): We were trying for May 8, so on May 8, we don't have any deputants except one person requesting; they were not scheduled. Would you like to cancel May 8 and then try to get all three on the same date?

Mr. Rick Bartolucci: Yes, move them so that we can maximize our time as well—

Mr. Jeff Yurek: Sure.

The Chair (Mr. Bas Balkissoon): Okay. All right. Then we would have to schedule it after May 15.

Now, I have another item: Your subcommittee had agreed that the committee meet on Wednesday, May 15 for the purpose of considering Bill 11, An Act to amend the Ambulance Act with respect to air ambulance services, but they never outlined the business of the committee for the day. Do you want to meet on the 15th, just to discuss what you want to do, or would you prefer to have a subcommittee meeting quickly and give the Clerk instructions? The 15th is not too far away; it's a week and a half.

Mr. Jagmeet Singh: I would suggest a subcommittee meeting for that. That doesn't sound like something that a full committee needs to meet on.

Mr. Rick Bartolucci: That's reasonable.

The Chair (Mr. Bas Balkissoon): Do I have the agreement of all? Okay. We will call a subcommittee meeting quickly, possibly tomorrow, for those on the subcommittee.

The Clerk has just brought it to my attention that because of the aggregates act, most of our dates are scheduled. The next meeting to bring GISA and OFSI together would be after the summer break.

Mr. Mike Colle: We could have a special summer session for GISA.

The Chair (Mr. Bas Balkissoon): Unless we ask the House leaders to meet. We're already meeting in a constit week, I believe.

Ms. Laurie Scott: They could agree to or not, but it's too late to change Bill 11 to Wednesday, right? Because we don't even know who we want to call.

The Chair (Mr. Bas Balkissoon): Well, we haven't called anybody. Unless you all agree to cancel the ambulance act and deal with the insurance and finish it, and we'll do the ambulance later.

Ms. Laurie Scott: That sounds like a subcommittee call, because there's no way you can get the ambulance act for this Wednesday, right?

The Chair (Mr. Bas Balkissoon): No.

Ms. Laurie Scott: We're sitting dead right before Wednesday now.

The Chair (Mr. Bas Balkissoon): That's right, so I need some suggestions. Mr. Singh?

Mr. Jagmeet Singh: I'm going to come back to my initial suggestion, then. If we're not going to be able to hear from either of them until into June, I think we should at least hear from one of them this Wednesday. We'll get the one independent person who wants to give his deputation and GISA. We get two of them—

Mr. Mike Colle: They've got to have equal time. We've got to have them both here together. It's not fair to either one of them to—

The Chair (Mr. Bas Balkissoon): If you listen to one now, the next one will be in September. This is the problem, unless you cancel the ambulance and you change one of the dates for the aggregates report writing that we agreed to already as a subcommittee and committee. We have some technical problems because there are too many items in front of us.

Ms. Laurie Scott: I think we should just go back to subcommittee and see what we can figure out. I mean, we estimated how many days we'd need for aggregate report writing, but we haven't even got the materials from research to see how long that's going to take, so it's very hard to figure this out.

The Chair (Mr. Bas Balkissoon): Let me just put it to you, and then we'll agree: So, we'll cancel Wednesday coming—

Ms. Laurie Scott: Sounds like it.

The Chair (Mr. Bas Balkissoon): —and the subcommittee will meet as quickly as we can to decide on all of the business of the committee, including the rest of the insurance and the rest of the aggregates.

Interjections: Yes.

The Chair (Mr. Bas Balkissoon): Okay. We'll call a subcommittee meeting, if we can, tomorrow, maybe after question period, or early afternoon, after 3 o'clock.

What we'll try to do is get the subcommittee members so you can notify. We'll try to do it tomorrow or Wednesday, the regular time, when the committee meets. I think Wednesday might be the best. Okay? Agreed.

Meeting adjourned.

The committee adjourned at 1655.

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Vice-Chair / Vice-Présidente
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Mr. Bas Balkissoon (Scarborough–Rouge River L)
Mr. Rick Bartolucci (Sudbury L)
Ms. Sarah Campbell (Kenora–Rainy River ND)
Mrs. Donna H. Cansfield (Etobicoke Centre / Etobicoke-Centre L)
Mr. Mike Colle (Eglinton–Lawrence L)
Mr. Rosario Marchese (Trinity–Spadina ND)
Ms. Laurie Scott (Haliburton–Kawartha Lakes–Brock PC)
Mr. Todd Smith (Prince Edward–Hastings PC)
Mr. Jeff Yurek (Elgin–Middlesex–London PC)

Substitutions / Membres remplaçants
Ms. Teresa Armstrong (London–Fanshawe ND)
Mr. Vic Dhillon (Brampton West / Brampton-Ouest L)
Mr. Jagmeet Singh (Bramalea–Gore–Malton ND)

Also taking part / Autres participants et participantes
Mr. Jim McDonell (Stormont–Dundas–South Glengarry PC)

Clerk pro tem / Greffier par intérim
Mr. Trevor Day

Staff / Personnel
Mr. Andrew McNaught, research officer,
Legislative Research Service