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Monday 15 December 2003

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Lundi 15 décembre 2003

Standing committee on finance and economic affairs

Comité permanent des finances et des affaires économiques

Automobile Insurance Rate Stabilization Act, 2003

Loi de 2003 sur la stabilisation des taux d'assurance-automobile

Chair: Pat Hoy
Clerk: Katch Koch

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

Monday 15 December 2003

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Lundi 15 décembre 2003

The committee met at 1005 in room 151.

AUTOMOBILE INSURANCE RATE STABILIZATION ACT, 2003

LOI DE 2003 SUR LA STABILISATION DES TAUX D'ASSURANCE-AUTOMOBILE

Consideration of Bill 5, An Act to temporarily freeze automobile insurance rates for private passenger vehicles and to provide for the review and regulation of risk classification systems and automobile insurance rates for private passenger vehicles / Projet de loi 5, Loi visant à geler temporairement les taux d'assurance-automobile dans les cas des voitures de tourisme et à prévoir l'examen et la réglementation des systèmes de classement des risques et des taux d'assurance-automobile les concernant.

COALITION OF REGULATED HEALTH PROFESSIONAL ASSOCIATIONS AND ALLIED ORGANIZATIONS

The Chair (Mr Pat Hoy): The standing committee on finance and economic affairs will come to order. We're here this morning for consideration of Bill 5.

Our first guests this morning are the Coalition of Regulated Health Professional Associations. Would you come forward, please. Good morning. Ladies and gentlemen, you have 15 minutes for your presentation. It can be made up of exactly that or you may want to allow some time for questions. If you would give your name and your organization for the purpose of our Hansard record.

Mr John O'Toole (Durham): On a point of order, Mr Chair: Before we begin proceedings, I'm wondering if the Minister of Finance is intending, as the author of this bill, to make any presentation before the committee.

The Chair: The subcommittee determined that it was not necessary to have the minister here for this bill. He was here for the prior bill.

Mr O'Toole: Nothing to do with this issue, though. OK, thank you.

Mr Toby Barrett (Haldimand-Norfolk-Brant): The prior bill did not discuss insurance.

The Chair: No, but the subcommittee determined that they did not require the minister for Bill 5.

Mr O'Toole: Peter Kormos is here, so it will be taken care of.

Mr Mike Colle (Eglinton-Lawrence): Mr Chair, just again to state on the record, we asked the Conservative subcommittee member whether he wanted a statement made and he said it wasn't necessary, that he instead wanted more time for deputations. That was the decision of the subcommittee.

Mr Peter Kormos (Niagara Centre): Mr Chair, if the government hadn't time-allocated the bill in the committee hearings, there would be more time for presentations by members of the public. So it's silly for the parliamentary assistant to say that the minister begged off so there would be more time. If the minister wanted more time for public participation, he wouldn't have time-allocated it and the Tories wouldn't have supported them in the time allocation.

The Chair: The Coalition of Regulated Health Professional Associations can begin.

Dr Carlan Stants: Good morning. My name is Dr Carlan Stants. I am the chair of the Coalition of Regulated Health Professional Associations and Allied Organizations. To my left is Jeff Lear, who is here representing the Ontario Association of Speech Language Pathologists and Audiologists. To my immediate right is Christie Brenchley, who is the executive director of the Ontario Society of Occupational Therapists. Further right is Marla Feldman, who is here representing the Ontario Association of Social Workers. Last, to my right, is Jim Christie, who is an actuary with the firm of Ernst and Young and who has provided actuarial analysis for the coalition with regard to auto insurance.

On behalf of the coalition, I would like to thank the standing committee on finance and economic affairs for the opportunity to speak before it today. In addition to this presentation, a number of our member organizations have invitations to speak separately later in the day.

From an historical perspective, the coalition was formed in October 2002 to serve as a collective body, a collective voice, for the varying professional health associations on matters related to auto insurance.

We understand the deep pressures on the past and present governments to stabilize auto insurance premiums. The coalition has always been committed to working with the government and other stakeholders in a collaborative, consensus-based manner to find ways to stabilize premiums while ensuring access without excess

to reasonable and necessary accident benefits for insured persons.

At this time, the coalition supports the Liberal government's Bill 5. We support the government's endeavour to protect consumers by reducing costs and making sure those savings are passed on to consumers in the form of lower rates. We support the government's current initiative to find appropriate ways that do not discriminate against any particular stakeholder group to achieve savings that will bring down auto insurance rates by an average of 10%. We also support the government's future initiatives to find appropriate measures that will maintain both availability and choice for consumers in obtaining auto insurance and ensuring the viability of the system. Finally, we support the government's long-term initiative to assess the practicality of customizing insurance plans that will allow consumers to save more by allowing them to customize their insurance coverage to best meet their individual needs.

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On a personal level, I have taken quite a bit of interest in the debate that has gone on in the Legislature with regard to Bill 5. However, one of the most overwhelming things I've noticed is the wide diversity in the knowledge base among the members of the Legislature on the issue of auto insurance. We are all here, ultimately, to try to find a product that meets the needs of all Ontario consumers. However, what I have noticed is that there seem to be an apparent number of myths that seem to be common to members in the Legislature.

One of these myths is that there is a valid database available to understand costs and to plan sound policies.

The second myth is that auto insurance premium rates are increasing because of the escalating costs associated with health care costs charged by health professional facilities for treating injured insured persons.

The third myth is that treatment care plans and fees paid to health care providers by automobile insurers can be brought closer to those of other payers, such as the WSIB.

The fourth myth that we notice is that designated assessment centres are a contributing cause of the rising cost of insurance, and that by eliminating the designed assessment centres, savings of over $100 million can be achieved.

The last myth that we notice is that auto insurance is mandatory here in the province of Ontario, and in an ideal world, the cost of this insurance would not be prohibitive and would provide insured persons with appropriate benefits should they be involved in an accident.

I will try to address these myths in order. On the issue of the valid data: It has become evident in the two-year process that the coalition has been involved intimately in the whole reform process that there is a dearth of good, accurate data upon which to build policy. We find that often this information is taken out of context. There have been recommendations toward the development of an independent data collection service that can be independently verified. The coalition has made that recommendation. We are trying to work with the insurance industry—certainly on the medical and rehabilitation part of the product—to have that type of process put in place. However, there is no initiative that I am aware of in the other sectors.

We also know, for example, that the information that is collected by the Ministry of Transportation is sadly lacking as to its accuracy with regard to the number of accidents and the number of injured individuals. I have had a conversation with the ministry prior to the most recent election and they openly admit that there is a lack in this regard.

Part of that problem is due to the fact that approximately five years ago, in 1997, we went to a self-reporting format with regard to reporting accidents. Typically what ends up happening is that if the accident is below a certain dollar value or if the person is not injured, you can self-report at a collision centre. The problem is that many times individuals who are injured do not start to show signs or symptoms related to their injuries until after they have reported and they do not go back to the collision centre to report those injuries at that time.

I've also talked to both the federal and provincial regulators with regard to the verification of the data that is presented to them by the auto insurance industry. They both indicate to me that they often take the data at face value, the reason being that they do not want to create problems with regard to solvency issues.

One of the few areas where we do have accurate data is with regard to the DAC system. This is due to the fact that DACs are required to report on a bimonthly basis to FSCO with regard to their activities.

When we talk about the myth around the auto insurance premiums increasing because of escalating costs, the hourly fees charged by most of the health professionals were negotiated with the insurance industry back in 1996. There has been no increase in those fees over the past seven years. The rate that is currently charged to the auto insurance industry is significantly lower than each association's current recommended fee guidelines. As we are all aware, there's a multiplicity of factors contributing to rising insurance rates: erosion of the investment market; high contingency reserves held by insurance companies; high re-insurance costs; high agent commissions; a substantial portion of costs attributed to medical rehabilitation are not related to treatment, ie, settlement costs or long-term disability benefits; there are high costs due to reported fraud; poor insurer internal claims management; and we have seen a rise in tort claims and settlement costs. Quite simply, health professional facilities cannot supply quality care and meet rising overhead costs at a rate below their usual and customary levels.

The third myth is: Treatment care plans and fees paid to health care providers by automobile insurers can be brought closer to those of other payers, such as WSIB. The important thing to understand is that you cannot

compare the WSIB and the MVA systems. They are not comparable. MVA injuries tend to be more complex, multifaceted and longer-lasting. There are different obligations in the system. WSIB's obligation simply is to assist the injured worker back to at least modified duties. Employers are required to accommodate the injured worker. There are no such obligations in the auto sector. Health professionals are obligated to assist, where possible, the injured person back to his pre-accident status. There are more administrative and reporting requirements from practitioners in the auto sector, which necessitates greater overhead costs.

What we found in the WSIB system is that, historically, fewer and fewer service providers are prepared to provide services in that area. There seems to be an admission from the WSIB that their fees are too low, and they have been working on developing programs of care which end up paying a higher rate to service providers as a consequence of that. It should be noted that the current professionals services guideline was imposed upon the regulated health professions; it was not negotiated. It represents a 30% to 50% reduction in professional health fees. In some cases, it takes professional health fees back 30 years. When you compound it with the other savings and reforms that have been brought in, it has the net effect of reducing fees in excess of 70% for health care professionals and facilities.

The fourth myth that I will address is with regard to the designated assessment centres, DACs, and that by eliminating them there is a possibility of saving over $100 million. The entire assessment sector is approximately $225 million. Of this, approximately $45 million is paid for DAC assessments of all kinds. About $25 million of that $45 million is paid specifically on issues around medical and rehabilitation benefits, approximately $135 million for insurer examinations and the balance for a variety of insured-person-initiated examinations. The average fee for medical and rehabilitation assessment is approximately $2,500. This is for the entire assessment, not on an individual basis.

Therefore, eliminating the DACs will not allow the government to save the $100 million that it is seeking to save. The DACs serve a useful and important purpose because they provide an objective, neutral, arm's-length, expert peer dispute resolution mechanism. It was this process that allowed the coalition to negotiate in good faith with the auto insurance sector and the government in bringing in the new processes that we see around pre-approved frameworks, around pre-approval of assessments etc.

It is the coalition's recommendation that the DAC system should be fixed rather than discarded.

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The last myth I shall speak to is the idea that in an ideal world auto insurance would not be prohibitive and insured persons would have appropriate benefits should they be involved in accidents.

From a medical-rehabilitation perspective, consumers are supposed to have access to $100,000 worth of reasonable and necessary goods and services over a 10-year period. That's what the policy says. There's an option which is seldom exercised. This speaks to the idea of customized plans for consumers to purchase $1 million worth of goods and services over a lifetime. The reality of the situation is that consumers get in the order of $1,500 worth of goods and services, and then are required to fight their insurer for the rest of it.

Increasingly, consumers are being required to dance through an ever-tightening series of hoops in order to access benefits they are legally required to purchase. Service providers are required to increasingly provide more paperwork and services at reduced fees, which is leading to accessibility issues for insured persons. There are proposals that would see the consumer's fundamental right to choose their service provider, which is entrenched in the Canada Health Act, by the establishment of gatekeeper roles by certain health disciplines and the establishment of provider networks.

The Chair: Excuse me, I just wanted to let you know you have about a minute and a half left.

Dr Stants: Thank you. When there's a dispute over a benefit, the consumer's ability to access mutual dispute resolution is being eroded by the proposal to eliminate the DACs, and there are increasing obstacles to consumers being able to obtain appropriate legal representation.

In conclusion, the coalition has made separate presentations to both the past government and the current government with cost-saving measures. We'll be happy to provide those. We have provided cost-saving measures that we feel will lead to about a 15% reduction in the current premiums. The fundamental principle is that there has to be increased accountability by all the stakeholders and that the cost savings should be spread across all the various sectors in the market. We feel there needs to be an independent mechanism for the collection of data. There also needs to be a strong, neutral, expert-peer, arm's-length dispute resolution mechanism.

Finally, the coalition looks forward to working with the government to try to achieve these measures.

The Chair: Thank you very much. We have time for a very short question. I'll allow time for the answer as well.

Mr Barrett: Very briefly, I want to thank the coalition and I want to thank Mr Lear for a letter he forwarded to me, which was submitted to this committee. I think it's the only submission to this committee, is that correct? Again, Mr Prue may concur, it suggests lack of time and lack of consultation. I think the previous committee—I don't think there were any submissions that were circulated when we were making decisions. It suggests to me that there's not enough time for proper deliberation of a very important issue, an issue that's very important for the victims, the children who are injured in accidents. I suggest this committee take the time to think about the victims and some of the problems that occur in this industry.

The Chair: Thank you for your presentation this morning.

ONTARIO MUTUAL INSURANCE ASSOCIATION

The Chair: I call upon the Ontario Mutual Insurance Association to come forward. You have 15 minutes for your presentation. You may allow some time for questions, if you care to. State your name and organization for our record, Hansard.

Mr Glen Johnson: My name's Glen Johnson. I'm president of the Ontario Mutual Insurance Association. Ron Perry is with me. Ron is manager of Lambton Mutual. John Knill, the underwriting manager from our reinsurance company, is caught in traffic, so he may come in at any minute. I want to read a brief introduction and then hopefully leave some time for questions.

These comments are made on behalf of the 47 members of the Ontario Mutual Insurance Association. All operate strictly in Ontario on an insurance-at-cost basis. They direct any profits into policyholder surplus. They only write participating policies, so every policyholder has voting rights. They're guided by boards of policyholder directors, who are typically farmers and small business operators in the community.

We recognize the importance of improving consumer confidence in Ontario's automobile insurance system. Accordingly, we can see the merit of implementing a temporary freeze for private passenger automobile rates as a first step in restoring consumer confidence. However, we stress that a rate freeze is a very small first step in correcting the rising cost of auto insurance in Ontario.

The sound way to reduce the price of auto insurance is to control the cost of the product, and specifically the claims costs. As an insurance-at-cost mechanism, with no incentive to make profits to provide to shareholders, we know that premiums are strictly a function of cost. We also know that all costs end up with the consumer. The better we can control those costs, the better we can control the auto insurance premiums. That's the challenge and that's where the focus should be.

The government needs to move ahead with product reforms and other cost control measures as expeditiously as possible. Specifically with respect to the content of Bill 5, we support clause 6(1), which allows an insurer to "apply to the superintendent for approval of rate changes that exceed the authorized rates if the insurer believes it is just and reasonable," having regard to its financial circumstances. Again, the temporary freeze is a small first step to the real solution, and an insurer's solvency should not be jeopardized because of it. The superintendent would only approve the application for higher rates if the circumstances warranted it anyway.

We encourage the government to only use the rate freeze as a method of gaining consumer confidence for the short run while the problem is substantially addressed through product reform, and that competition within the industry then be allowed to work as it should. A prolonged rate freeze or any other artificial price control could have a detrimental effect on the industry and consequently adversely affect availability.

The Ontario farm mutuals' rate filings are prepared on a group basis by their jointly owned reinsurer FMRP, Farm Mutual Reinsurance Plan Inc. Farm mutual auto insurance rates are currently well below the industry average. We had applied for an increase in late September. This request was not approved by FSCO before the October 23 rate freezes. Therefore, we currently lag behind many companies in our industry that had received approvals for rate increases earlier in the year. In addition, under the second phase of the government's proposal, we will be expected to roll back rates by an average 10%.

This situation places the Ontario farm mutuals at a disadvantage. Nevertheless, and this is what I want to stress, we recognize the need for the rate freeze, but we urge you to expedite the necessary product reforms that will alleviate the cost pressures that drive premiums upward. We believe that if you take this opportunity to make the appropriate product reforms, healthy competition will have its effect in lowering premiums.

Further, we recommend that Ontario move to a file-and-use rating system with benchmark rates, which would enhance competition and provide long-term rate stability. The current rate filing process has not achieved that goal. We need to bring healthy competition back into Ontario's auto insurance marketplace.

We also urge you to encourage and join with the insurance industry in a campaign to help consumers understand the forces that affect their auto insurance premiums. Most importantly, consumers should understand that premiums are affected by claims costs more than any other force. We cannot make positive change to price and availability problems without addressing claims cost in a meaningful way. It is important that consumers understand that.

Attached to these comments is our paper entitled Bringing Positive Change to Ontario's Auto Insurance System. In this paper we've made a number of specific recommendations, most aimed at controlling claims costs. This is the real solution.

To reiterate the conclusions of our paper, as we see it, the formula to controlling rising auto insurance premiums is as follows: help consumers to understand the forces that affect the cost of insurance and the price-coverage trade-off; move to a more predictable system for first-party benefits for non-catastrophic injuries such as a strictly defined schedule of benefits with strictly defined dollar maximums; bring back a strong OMPP-type threshold, which is restricted to physical injuries; implement cost control measures for health care providers such that payments are similar to what they receive from WSIB; and implement consumer protection legislation to make it illegal for any business licensed in Ontario to have a two-tiered pricing system—one for insurance claims and one for "no insurance situations."

We appreciate the opportunity to provide input. Hopefully, there's some time for questions.

1030

The Chair: Thank you very much. We have about two minutes for each caucus. We'll continue the rotation and start with Mr Prue of the NDP.

Mr Michael Prue (Beaches-East York): I'd just like to zero in, in my two minutes, on your recommendation that you "implement cost control measures for health care providers such that payments are similar to what they receive from WSIB." The previous group said to do diametrically the opposite of that, that the WSIB was too low and that they had negotiated in 1996 and hadn't had a raise. Why are you recommending something that is totally at odds with the previous group?

Mr Johnson: Obviously, here we're dealing with a product that's costly, and we're trying to find ways to get the cost down. It just seems to us that if we're going to compare the cost of auto insurance and the benefits it provides, it has to operate in the same environment as do the other things, like WSIB, OHIP and so on. It's really not fair that the auto insurance policy be left to pay a different rate. The consumer sees that in the form of the fact that, golly, their auto insurance is too expensive. It's a cost that's in there.

Mr Prue: So these people who have not themselves had an increase since 1996 should expect a decrease?

Mr Johnson: It wouldn't be a decrease; it would be putting us back on the same level as other people who are paying fees. I suppose in a sense if you wanted to look at that as a decrease, maybe you could, but it seems unfair that the auto policy has to pick up that extra fee, and the consumer really doesn't see it other than the cost of their auto insurance as being too expensive. It doesn't come out. What drives the cost of auto insurance? If it's fair in those other jurisdictions, it should be the same level playing field for the auto policy as well.

The Chair: We'll move to the government caucus.

Mr Bruce Crozier (Essex): Good morning. In our attempt to either minimize or reduce costs in the insurance field, you have stated that you recommend that we move to a file-and-use system. How will this help us do that?

Mr Johnson: Unfortunately, our person who could answer that best is the one who didn't make it, but it would be less structured, I guess. There would be benchmark rates, which would be an average that is charged within the industry, and then there would be leeway one way or the other as far as what a company could charge.

What we're really saying is, bring back competition. Let the insurance companies compete with each other, and that will achieve the price efficiency. At any point in time, we don't know the real price. We only know the real price after we sell the product because of the nature of the product. We're either too high or too low at any given point in time. It's competition that's going to bring that price down to the right level. There's a diagram in the paper on page 6 that shows the insurance cycle.

Mr Crozier: But if file-and-use simply means that they can file their rates and go ahead and use them the same day as they filed them, what I'm trying to get at is, how does that reduce costs? Are there significant administrative costs that can be saved doing that?

Mr Ron Perry: Yes, there are, and as Glen has pointed out, unfortunately Mr Knill is not here to give you those exact costs for our industry. I can tell you that it is very expensive. By the time you bring in actuaries and so on and have to put together a presentation to give to FSCO, it will oftentimes take three to four months before rate approvals are received. As a matter of fact, the cost of it is one reason why we as mutual companies pool together and have that done by Farm Mutual Reinsurance Plan Inc, so that we can share that cost. It would be cost-prohibitive for small companies the size we are as individuals to have to put forward a rate filing with all the work. It's very complex, very expensive.

Mr Crozier: Chair, might I ask that maybe they could provide an explanation of file and use for the committee and we could get that later?

The Chair: If they would care to, we'd appreciate it. We'll move to the opposition.

Mr O'Toole: Thank you very much for your presentation this morning. It's an ongoing debate. I have just a couple of points. I agree with you that the claims cost is really the focus that drives the pooled risk—how much it costs.

I look back at the Liberal plan in the late 1990s. We really had rate capping and they had an attempt to eliminate that. But when they had rate capping, the actual rates went up 17.8%. The history is there. Even if I look at the current bill, there is, "The minister may allow." It's mentioned all throughout the bill, to allow rate into the system. There's no guarantee that rates will actually stay down.

If I look to the history, the Ontario motorist protection plan, which was the Liberal plan—some have said even more recently in the Toronto Star that it really hampers access to the system for victims; that's really what it does. If you look at their plan, it's clear they want to eliminate the DACs, the assessment for access to treatment. Do you support that? That's one question.

The second one is, we had entered into an expedited rate filing, which was really file and use in a much less sophisticated way. If you could comment on both those things and if we were on the right track, I'd appreciate it.

Mr Johnson: With respect to the DACs, we would support reforming the DACs. There are fixes that are needed with respect to timeliness and finality and things like that. But we would support a system of reforming the DACs rather than doing away with them.

On the rate question, I'm going to defer to John Knill, who's with us now.

Mr John Knill: I'm sorry, I missed your specific question on rate filings.

Mr O'Toole: Yes, we were entering into a period like file and use but it was called expedited rate filings; really more a file and use, but they would be reviewed afterwards, avoiding the cost, as Mr Crozier was asking about, of managing the business plan with respect to the actuaries and all the reports necessary to justify the rates.

Was that the right system or is there some comment you could make with respect to file and use and expedited rate filings?

Mr Knill: I believe the file and use system would be much more appropriate. It would be much more cost-effective. It would also allow the regulators to quickly determine whether or not companies or groups were filing the appropriate rates as opposed to the current system now, which is somewhat of a negotiated filing system.

Mr Barrett: I wanted to jump in just to say thank you to OMIA for being here. You're mutual companies; you're different from the stock companies. You've been doing something right. Many of your companies have been around for well over 100 years. I appreciate your comments on the value of competition and cutting costs. Your companies can do it. You're not sitting in high-rises in large cities. You're very close to your customers. I also—

The Chair: Your time has expired.

Thank you very much for your presentation this morning.

ASSOCIATION OF CANADIAN CAR RENTAL ORGANIZATIONS

The Chair: I will call upon the Association of Canadian Car Rental Organizations. Welcome to the committee. You have 15 minutes for your presentation. As you've seen this morning, you may allow for questions if you so desire. If you'd please state your name and your organization for the purposes of our record, Hansard.

1040

Mr Sid Kenmir: Good morning, committee members, and thank you for hearing our presentation on Bill 5 today. I am Sid Kenmir, president of the Associated Canadian Car Rental Operators, which is called ACCRO. ACCRO represents the vast majority of vehicle rental firms in Ontario. I am here today representing the views of the vehicle rental industry on Bill 5 and auto insurance generally.

Also here with me today are Jim Bell, president of the Canadian Taxicab Association as well as the Toronto Taxicab Alliance, and Philomena Comerford, president of Baird MacGregor Insurance Brokers. Baird MacGregor is the insurance broker for the majority of the car rental and taxicab firms in Ontario. Also with me is Mike Dearden, who is the public affairs adviser to ACCRO.

I have a short statement I would like to read, and then we would be happy to answer any questions. I have provided copies of my presentation to committee staff.

First, by way of background, I want to tell you that there are over 4,000 licensed taxis and 7,500 licensed cabbies in Toronto. Across Ontario, it is estimated there are well in excess of 20,000 licensed taxicabs. The vehicle rental industry in Ontario employs over 6,000 people. We own and operate over 45,000 vehicles. Our most recent figures, which are several years old now, show that our industry pays over $82 million in taxes and fees to the Ontario government annually.

The vehicle rental industry in Ontario is the largest single operator of vehicles in the province. On any given day, we have as many as 30,000 cars on the road in the GTA alone. Annual revenues for vehicle rental firms in Ontario are in excess of $750 million.

Vehicle insurance has always been a significant cost of doing business. The last few years, however, have seen rate increases unlike anything we have previously experienced. Like individuals, the rental industry has responded by taking on more and more of the risk associated with vehicles. Some rental firms are completely self-insured for collision and comprehensive damages. While we have had some success in this regard, the cost of insurance for bodily injury coverage has hit us very hard—50% increases in premiums are not uncommon for some smaller firms. So for the vehicle rental business, soaring insurance rates are not just an inconvenience, they strike at our livelihood.

The main factor driving up insurance premiums is the payout for bodily injuries. Medical care, rehabilitation treatments, cash settlements, legal costs and awards have escalated incredibly.

The vehicle rental industry sees Bill 5 as a first step toward fixing the rate increase problem. While Bill 5 applies only to private passenger vehicles, and hence does not immediately help us or other commercial operators, we see this as a positive first step. We have reviewed the proposals of the new government in terms of changes to the system, and we support the goals of the government.

Bill 5 signals a government that is willing to take the decisive action necessary to correct the serious problems in our current auto insurance system. We in the vehicle rental industry want to work with the government as they move forward with fixing these problems.

Rental firms and cab companies represent a canary in the coal mine for auto insurance. Recent studies have confirmed what we have experienced for some time now: Rental cars and taxicabs are the vehicles of choice for organized crime as they set out to defraud the Ontario auto insurance system. Using rented vehicles, criminals stage accidents and then defraud the insurance system at every step of the process, often with the help of so-called service providers to the industry.

We have shared our concerns and suggestions a great deal with both the previous and current governments. I have copies of papers we have provided in response to the various government proposals for change put forward over the last several years. I would be happy to provide copies of these papers to any members of the committee who would like them.

We in industries that depend on vehicles and hence auto insurance to make our living have no illusions about the challenges the government faces in trying to fix auto insurance. There are powerful interests who like the system as it currently operates and don't want to see change, certainly not change that would in any way

lessen their profits. But the buyers of auto insurance, be they individuals like the members of this committee or organizations like ours that run fleets of vehicles, must be able to have the choice of buying reasonably priced auto insurance coverage that will provide protection should the need arise.

Let me conclude by sayings that the rental vehicle and taxi cab industries support Bill 5. Although we do not immediately benefit from it, we see Bill 5 as the first step in bringing the real change necessary to ensure we can afford car insurance that will protect our cars and people. We look forward to working with the government as it fixes the auto insurance system in Ontario.

Thank you, committee members. We would be pleased to take any questions.

The Chair: Thank you very much. We have two minutes per caucus.

Mr John Wilkinson (Perth-Middlesex): I'm interested in a little bit more elaboration about what steps you see we could take as a government to try to reduce what can be described as an epidemic of fraud, where your cars are being used by organized crime to perpetrate insurance fraud. Do you have specific proposals you've presented?

Ms Philomena Comerford: We have concerns about certain aspects of the legislation. We think telephone mediation is a problem because of the fact the claimants are not present. We are concerned about the dispute resolution system and the fact it facilitates—there's very little investigation possible when claims occur because of the fact that it becomes almost like negative billing because of the entitlement that exists. The ability to close files before a year elapses is very important because the open caseload will become a problem for fleet operators. Also, reform of the collision reporting centres is important as well. The way claims are reported, the problem starts there.

No attendance at the scene is a problem. Sharing of arbitration and mediation costs is important to the degree of success. We think that would help. There is no downside to putting everyone through their paces. Section 24 assessments are very costly, in addition to the assessments that are presently taking place, and they are a duplication of effort. The ability to investigate double-dipping through some recognized system that the claimant is aware of is important. The type of claimant that does this tends to be the type who double-dips elsewhere.

Mr Wilkinson: Do your members have an easy mechanism, if they have suspicions of fraud, to try to get it to the appropriate people, or is that cumbersome?

Ms Comerford: It's very costly.

Mr Wilkinson: So if I owned one of the firms and I got this feeling that it was a bad situation, is there an easy way for me to pass that along to law enforcement?

Ms Comerford: No. They're powerless because of the fact that the legislation ties everyone's hands. They have to do certain things and unless they have really clear proof—you're talking about soft tissue injuries, so it's very difficult to prove.

Mr Wilkinson: We appreciate your support of Bill 5.

Mr O'Toole: Thank you very much for your presentation. There are a couple of issues you've mentioned that I will follow up on. You say you support the bill; on page 4 of your presentation you support Bill 5. On what basis do you support Bill 5? It actually doesn't do anything that I'm aware of.

Mr Mike Dearden: We support the bill, as we say in the presentation, Mr O'Toole, based on the fact that it indicates the government is willing to take necessary action to correct the situation. It's just a first step, and that's the way we identify it. We suggest it does not apply to us directly because it's only private passengers. What it does for us, however, is send a strong signal and I think it sends that signal to the industry. That's why we support Bill 5, because it sends a signal of change.

Mr O'Toole: I like the term "real change." It looks like you've read their document. I have read their document and even in there, if you look at the clause dealing with—pardon my voice this morning—low rates for change, they're going to actually define in regulation permanent and serious impairment. Oddly, injury is one of the driver costs here. I'm not sure if that is true of your industry. Under what guidelines that you are aware of—you are supportive of this bill, so obviously you've read it—are they dealing with permanent and serious impairment, and does that mean people, including children, who are catastrophically injured will be limited as to treatment? That's a cost driver.

1050

Mr Jim Bell: There's no doubt, and we say it in our report, that bodily injury is a huge cost driver in the whole process. That issue is not dealt with in Bill 5. We look forward to working with the government as they do grapple with that issue. It's been an extremely difficult one for all governments. As we said, we are under no illusions about the complexity of the situation. However, we think that with good-intentioned people who believe the importance of insurance is protecting the individuals who purchase it, we can fix that problem, so long as you're willing to deal with some of the vested interests.

Mr O'Toole: I guess the key, and I'd like to just make sure than on record—

The Chair: We'll move the NDP and Mr Prue.

Mr Prue: I'd like to zero in on the top paragraph on page 4. This is hugely strong language, and I want to make sure you can back this up. It reads in part, "Rental cars and taxi cabs are the vehicles of choice for organized crime"—I need to know what organized crime you mean by that—"as they set out to defraud the Ontario auto insurance system. Using rented vehicles, criminals stage accidents and then defraud the insurance system at every step of the process, often with the help of so-called service providers to the industry." First of all, who is the organized crime, and who are the service providers who work, I guess, for the government or government agencies who are providing help to organized crime?

Ms Comerford: Actually, I know there have been some operations where they've been able to identify con-

nections with paralegals who have been working with, quite often, body shops, tow truck operators, and they will refer business back and forth. We had situations where there were six car rental companies in two jurisdictions involved in a ring and there were connections. They were able to establish a connection through investigative work that had been done.

Mr Prue: Again, "organized crime" has a very solid meaning, what it is. It's crime that launders money; it's crime that gets money usually from drugs, prostitution and other things like that.

The service providers you're talking about are paralegals?

Ms Comerford: I don't think the intent was to suggest they are involved in other types of organized crime, but specifically accident benefit fraud. It happens in the US as well, because you can rent a vehicle and disappear into the woodwork. People will rent vehicles, sell seats in the vehicle, and claim to have had a bodily injury. Frequently the claim is one that happens in an isolated area, no witnesses, and there are many disparities in the evidence that follows. They are represented by the same paralegal, they frequently go to the same treatment centres, and it's known that there are kickbacks going to tow truck operators and the like. That's happening with a fair degree of regularity, but it's difficult to investigate. It's very expensive to investigate and prove.

Mr Prue: Is there anyone else other than paralegals whom you are referring to as service providers?

Ms Comerford: Tow truck operators, collision repair shops, treatment centres that work together, hand in glove.

The Chair: Thank you very much for your presentation this morning.

Mr Kenmir: Thank you for having us.

JIM ST JOHN
BILL ANDRUS

The Chair: I would ask the Ontario Kinesiology Association to come before the committee. I'm sorry; it should be Jim St John and Bill Andrus first. If you would state your name for the purposes of Hansard, and be reminded that you have 15 minutes for your presentation. That can be solely for presentation, but you might allow for some questioning at the end.

Mr Jim St John: I'm Jim St John. This is my colleague Bill Andrus. We're from the Consumers Association of Canada, Ontario branch. It does not say that in the presentation; however, due to time constraints, this had to be an unofficial, unapproved submission.

We'll take a somewhat different approach than the prior presenters. We will make our presentation by reading the executive summary. I will do that. I invite questions during the reading of it, if you have any. Similarly, when Bill gets to his part, he will read the second page, which refers to the text, but will not try to read the entire text. Bill will also welcome questions during his reading. You don't have to save your questions until the end.

I have difficulty enunciating. If you have any difficulty hearing me or understanding me, please do not be shy and just say so.

This paper says that Ontario consumers support the principles of auto insurance affordability, accessibility and stability. We look to reduce costs without reducing benefits, since accident victims too are consumers. They both pay the premiums and experience the accidents. The 1996 changes to the insurance product already reduced these benefits as far as practicable. I'm aware of that because at the time I was a government employee working on this subject. Since then, I've retired.

The GTA represents 30% of cars insured, 39% of premiums, 42% of claims, higher traffic density and accident frequency, and it has an advisory infrastructure which encourages consumers to make claims, whereas in the rest of Ontario a claim is not ordinarily made. The rest of Ontario simply says, "Suck it up and go on with life."

Over five years, the average cost of claims in the GTA has increased 10.7% per year versus 4.7% outside the GTA. This suggests that the auto insurance crisis which we're currently facing in terms of premiums is primarily a phenomenon of the greater Toronto area. If you go outside, to Kenora or Kingston, you will not find the same concern with auto insurance that you find in Toronto.

Even if the government were interested in moving to public auto insurance, it would take time. Change is needed immediately. Our immediate savings proposals include 4% to 5% savings by reducing broker commission from 12.5% to 8.5% and eliminating profit-sharing schemes, in effect offsetting the windfall profits accruing to brokers from premium increases. In other words, premiums have gone up by about 20% in the last year, according to FISCO, and another 20% the year before that. Since the broker's commission is a percentage of the premium, their commission has gone up as well, without any attendant increase in what the brokers have to do. These increases constitute a windfall profit for brokers.

We would also note that if you turn to other jurisdictions, various provinces in Canada, particularly the ones that have public auto in form or another, they also use brokers, but brokers only get 8% to 8.5% commission in each of their provinces. We don't think the amount of work in Ontario is significantly different than the amount of work in those provinces for their brokers. We recognize, though, that brokers would not be happy with the idea of a cutback in their commission, even though part of it is windfall, and we have something for them as well; that is, we would make this more acceptable to brokers by mandating their access to all insurance markets, as currently they only have access to two or three companies. Bill will go into this in greater detail in his presentation. The proposal is that they should have the ability to place their business with any company, not

just the two or three they represent at the moment. This will restore the function of the broker, and the image the public has of a broker when they go to a broker to buy insurance.

1100

We would obtain another 1% saving by reducing the surcharges on monthly premium payments. These surcharges are about 3% per month at the moment, 50% per year. We don't think there's justification for the current rates being that high in a non-inflationary environment.

We would save another 1% by reducing Ontario's premium taxes. The previous government announced a reduction in premium taxes from 3% to 2%. We think this government should do the same thing.

We would save another 1% to 2% by reducing company overhead expenses and other significant savings, harder to quantify. Particularly in the GTA, it would by achieved by allowing companies more latitude to control advisory expenses, such as the tow truck operators, paralegals and body shops.

That's the end of the executive summary. Do you have any questions before Bill Andrus launches into his?

Mr Bill Andrus: Perhaps very quickly just to go through the rest of it, the way I would suggest we organize it is that we have two pages here of a point summary of the attached presentation and then the presentation, albeit it's 15 pages. I'll refer you to a specific graph and a specific page to quickly go through it.

To start off with, I would say we wanted to take a look at the claim costs. Let's look at the numbers, let's look at the real data, what's going on out there. Please refer to page 1, graph 1. If you look at that graph, those are claim costs per insured vehicle in Ontario. All data came from the Automobile Statistical Plan database, which is a very, very good database. It is contributed to by law by all insurance companies who are writing auto insurance in Ontario.

If you look at this graph, those are the claim costs. That is, in effect, the behaviour of the consumers and the compensation that the consumers are getting. I might suggest that it's probably the most boring graph you'll ever see in your life. There's nothing exciting going on here. There's no crisis. In statistics, you might refer to that line as a frozen rope. That's a stable, solid business, although it's going up at 7.8% per year. We can look at that. That is not a crisis. We're not hearing rate increases of 7.8%. We're hearing 20%, 30%, 40%. So we've got to dig deeper.

Please refer to page 2, graph 1.25. That's where we split the claim costs to the GTA and the remainder of Ontario. Clearly in the GTA, there is a different set of issues at force here. There's something going on. On the good side, though, the remainder of Ontario is even more safe. This is not a crisis, at least on the claim side. So we've got to find out where this volatility is coming from.

The growth in the GTA is approximately 10.7%, 7.8% in the province over all, and 4.7% outside. It's hard. We have to sit back and say, "Look, why does a soft tissue injury in Stratford, in Chatham, in Sarnia, in Timmins cost so much less than a soft tissue injury at Yonge and Eglinton?" So we keep working, finding out. Maybe it doesn't.

We move forward to page 3. Now, this is stability in the system. Back to graph 1. The way you make rate filings in this province is that you go forward, you put your expected costs down and you, or the insurance companies, are allowed 25% margin, roughly, for overhead and profit, et cetera. If it was working well, the dotted line would represent our premiums. It would be falling in line with the claim costs over time. Again, it would be nice, uniform and stable. That is not what is happening.

So let's go forward. Please, page 4, graph 2. What I did here, although the scale is a little bit different, is that I put in the average premium. These are actual dollars paid for all lines of insurance—collision, comp, third-party liability, everything. It's all in there as it is in the claims. You can see there is a level in the average premium. Now, the average premium is moving up sharply.

Please move to page 5, graph 3. What I did there, that vertical line represents a projection. Everything to the right is a projection. Fortunately, on the premium side we don't have to project; we know the facts. Fiscal was recently putting out—there was a thing on the Web site—saying that the 12-month actual, real premium increase over all was 19.3. I think I may be off a couple of points. So that vertical line, top line, represents the 19.3. That is not a projection; it is a statement of fact.

Now then, we look at the average claim costs and the stability. I suggest one does not have to be a rocket scientist to project that very stable curve. We fit a line through that. It's a very stable fit. So you can see the gap widening. These are the numbers. This is it. That gap is spreading very quickly.

Now then, on page 6 I split that between the GTA and the remainder of the province. That graph is wrong—I'm the first to admit it—because the rate increase we used for the province was 19.3. We have anecdotal evidence that if we could split it by GTA and the remainder, it would be more in the GTA and less in the remainder. Therefore, we are underestimating the gap in the GTA graph and we are overestimating the remainder.

The points here that we want to make is, if there's volatility in the system, it's hard to find the evidence that it's coming from the claims side. We hear a lot of words. Where's the evidence? We think we can produce the evidence from this, which is a highly credible database, that there is a lot of volatility coming from the supply side of the equation—the insurers.

Why is that? Please refer to page 8. I'll try to go through this very quickly. Time is running short. But what we would like to say, with respect to Bill 5, we think the graph on pages 5 and 6 support Bill 5. It's appropriate both in timing and intent. It is time to do this; take this period of a freeze on rates, maybe even make it

longer. Let's stop, look and listen and see what's really happening in the system, but look at both sides, not just the claims system. Let's look at the other side, the supply system. That's what we're trying to do here because we couldn't find the volatility in the claims side. You can't get it.

So I totally, absolutely support Bill 5. Maybe it should be a little bit longer to give you enough time to stop, look and listen.

Moving forward, there is an interesting thing here and I'd like to refer you to page 9, table 1. The point we'll want to get to here is that to have a free market system, you have to have competitors and you have to have access to the competitors. Let's look at table 1, page 9.

The Chair: I remind you that you have *[inaudible]* minutes left.

Mr Andrus: I'm out of gas.

The Chair: Continue.

1110

Mr Andrus: On table 1, in 2001, there was a study done by the Consumers' Association of Canada. It was done for different purposes than this, but I've at least used some of their material to be able to show what we've got here.

In 2001, they went out to 10 auto insurers operating in Ontario and they developed 30 different profiles, 30 different fictitious John Does, and they got quotes. Profile number 1 was a pretty mundane profile—they're back in exhibit 1. This family has two vehicles, but it had some sort of a wrinkle in it, and you get the details on the profile. I don't think it's that important for the point I want to make. But you have 10 different insurers on the profile: the lowest quote, $1,795; the median or middle quote, $1,982; and the highest quote, $2,501. That's a hell of a swing for exactly the same risk. If those people who are paying the highest moved to the lowest—it's got exactly the same product—they save 28.2%. The median people would save 9.8%. Even going from high to median, you'd save 20.8% and you've got exactly, precisely, the same product. You can quickly eyeball columns 5, 6 and 7. These are very serious savings.

What we have, we submit, is a supply system in which there is a lot of competition, but you can't get at it. Based on what we saw in table 1—shut me up whenever you want; I'll just keep going until I'm told to leave—based on this understanding, why are consumers not purchasing their insurance from the cheapest insurer? The answer has to be that they don't know that the rate exists. They don't know it's there. Why don't they know it's there? Now we have to look at the supply side. We have put in—

The Chair: Mr Andrus, I think we'll have to allow our committee to read the rest of your report—very interesting—at their leisure. We appreciate both of you coming before the committee this morning.

Mr O'Toole: In the interim *[inaudible]* the next presenter, there's one more example where the whole input on this is almost a sham.

I appreciate the time you've taken to prepare this and to present it—

The Chair: Your party agreed to the proceedings this morning, Mr O'Toole. It's not a point of order.

ONTARIO KINESIOLOGY ASSOCIATION

The Chair: I would call forward the next group, the Ontario Kinesiology Association.

Interjection.

The Chair: Mr O'Toole, come to order.

Good morning. You have 15 minutes for your presentation. That can be made up of presentation and/or questions. If you would please state your name and your organization for our Hansard record.

Ms Conny Glenn: My name is Conny Glenn. I am the president-elect for the Ontario Kinesiology Association.

Mr Stephen Skyvington: My name is Stephen Skyvington. I'm the vice-president of PoliTrain Inc.

Ms Glenn: The Ontario Kinesiology Association is glad to have the opportunity to present to you this morning with regard to auto insurance rates. The association is comprised of 1,500 members, certified kinesiologists who work in the province of Ontario. We are a self-regulating health care group. We've worked in the auto insurance sector for well over a decade, providing health care services.

Just to give you a bit of background on our membership before I proceed to talk about the specific issues, certified kinesiologists graduate from roughly 13 different universities in the province of Ontario. They obtain a four-year bachelor of science degree in kinesiology. Part of that degree is that they must obtain courses in biomechanics, anatomy, physiology and psychomotor behaviour. We are specifically educated and trained to provide rehab services such as therapeutic exercise and assessments. We also work in various other sectors within the province, health and safety being one of them, ergonomics, and health and wellness.

We have some very specific concerns with regard to auto insurance. Since the change in regulations that became effective both October 1 and November 1, we have experienced some significant difficulties as well. I'm here to bring that to your attention and tie that into talking about the rates that are of great issue at this point in time.

Currently, the Ontario Kinesiology Association is here to tell you that we are in support of a rate freeze at this time. We believe it is crucially important to review the system as a whole. The previous changes to auto insurance regulations attempted to stabilize rates and did so at the expense of both health professionals and the injured accident victims. Rate stabilization and/or reductions were not realized by the public.

The specific issues that we're trying to bring to bear have to do with provision of services to injured victims, and those costs. Under the previous regulations there was an assumption made that the increase in cost, which therefore drove rates up, was directly attributed to in-

creased rehabilitation and accident benefit costs. We disagree with this. I think making health care professionals the culprits in the rising cost is like me trying to convince you that I'm actually a natural blond.

Mr Prue: You mean you're not?

Ms Glenn: No.

Mr O'Toole: That's a convincing argument.

Ms Glenn: Our first issue we want to inform you about is with regard to the previous regulations, and I'm specifically referring to regulation changes under the statutory accident benefit schedule. The changes that became effective October 1 changed some wording in the regulations, specifically the wording "health practitioner" and "health professional." The term "health practitioner" is defined as a regulated health practitioner, someone who is regulated under the Regulated Health Professions Act. As I've mentioned, kinesiologists are self-regulating. Despite having an application for regulation since 1995, we are not RHPA-regulated. The definition, as it stands in section 2 of the statutory accident benefits, precludes us, then, from being able to provide services that we've provided for over a decade.

The other term that's used, "health professional," is undefined. So throughout the act you see a switching back and forth of the terms "practitioner" and "professional." However, what has occurred since October 1 is the interpretation that "practitioner" and "professional" are synonymous.

Since October 1, we've seen an estimated 30% job loss among our membership working in this area. Those who have not actually lost their jobs have seen a reduction in the amount of work they're doing, or they've been constructively dismissed, remaining at the companies they're at yet unable to provide the services they once provided. Where that comes into play with the public is that there are fewer choices for them in terms of providers. Again, less competition, less provision of services.

As I mentioned, kinesiologists are skilled and educated in providing exercise therapy. Exercise therapy is the one scientifically, universally recognized form of therapy that returns people to activity faster than any other. The very people who are considered by the courts and others to be experts in this are now precluded from providing this service within the system. The result is actually an increase in costs. You can take an injured victim, give them the services they need—active exercise therapy—and they return to their activities quicker. What happens then is a decreased need for benefits, specifically income replacement and associated benefits. By decreasing the costs, you are then able to keep your rates down.

That is ultimately what I believe we're trying to achieve. We're asking that the wording be changed in that particular part of the regulations to put us back into the model. We would like to see the definition "health professional" used to include health practitioners as well as certified kinesiologists, those who are certified by the Ontario Kinesiology Association, and that the term "health professional" be used throughout.

Our second issue has to do with the regulation changes that occurred on November 1. Those involved a change in the rates that providers were allowed to bill. The rates were mandated and not negotiated. Our primary issue, aside from the lack of negotiation, was that originally we had been told that there would be a maximum 30% reduction in billing rates. Our groups saw 60%. I think anyone who has owned a business can well understand that having your rates reduced by 60% makes it economically unfeasible to own and operate a business in this kind of sector. As I mentioned, we've seen job loss. Kinesiology-owned businesses have moved out of the sector or had to fold, and other employers who employed kinesiologists have had to let them go because they cannot justify keeping them on staff when they are only allowed to bill this minimal rate. So it hasn't been just unfair to us; it has been unfair to the other health providers as well, but specifically we've been greatly harmed by this. The result, of course, is that the accident victims who are looking for these benefits and services then suffer because we are no longer in the system; there's a lack of competition and they don't get the services that they require and should have.

1120

We're requesting that the rates be put back to the preset levels they were at, and if the rates need to be changed, that they are fairly negotiated with the health providers. I think you'll find that all health providers are reasonable in this regard in being willing to negotiate, but we need to be included in the process to help stabilize rates to help keep the costs down. That's what we are hoping to get in terms of coming to you.

I have a couple of other thoughts with regard to the rates in discussions with my fellow kinesiologists. I myself have worked in this sector for well over a decade, under various pieces of legislation. The thing I continuously see is an increase in the amount of administration and paperwork required to do the same thing that I was doing 10 years ago. So a streamlining of the system I think is in order. Having health care providers fill out more and more paperwork takes them away from the thing that they were specifically educated and trained to do: to provide services that would get people better, and get them better faster, thereby reducing costs, and so effectively streamline the paperwork. Don't make us sit and fill out reams and reams of paper. Allow us to do the jobs that we are trained to do so that we can effectively work within the system.

Does anybody have questions or comments?

The Chair: We have about a minute and half per caucus. We'll start with the official opposition.

Mr O'Toole: Thank you very much for your presentation. I'm going to take some issue—I suppose I would be naive not to assume that you want to become a member of the Regulated Health Professions Act. That's a given.

The other thing you talked about, streamlining red tape more or less by the amount of paperwork: I couldn't agree more. I think that process is all the assessments. If you want to comment on that, I'm just opening it up,

because there's clear evidence they're going to eliminate the DACs, basically that's the plan, and put it under the direction of the doctor, probably the general practitioner. I wouldn't want to assume anything.

We did introduce a kind of standard invoice. I'd like you to comment on that. The standard invoice was to address the fact that you had a chiropractor, a physiotherapist, a psychologist; it's pretty hard to do any case management—somebody at the insurance or somewhere, the doctor, the attending physician, whatever. Who's figuring out what's actually happening here when the person is in very serious trauma, shock, psychologically stressed, whatever? The DACs, the standard invoice, and who's managing the care: Could you comment on those?

Ms Glenn: I think you'll find that the bulk of the kinesiologists are in support of having either a doctor or a chiropractor as essentially the gatekeeper. We do have concerns, though, given the shortages of doctors available, that this might be difficult. We work very well with the other health care practitioners in providing care.

In terms of assessments, there definitely has been an excess of assessments. Although the people working within the DACs provided good-quality assessments, we do feel that the DACs' assessments are an additional, third assessment, whereas the original system was designed to allow the injured party to get an assessment to determine benefits and then the insurer to get an assessment so that they could mediate some sort of arrangement in between. The DACs seemed to have been a third step on top of this that we feel has been unnecessary. We also believe that by eliminating the DACs, those people who were working in that system can then come back into the rest of the system, thereby alleviating what we feel is a shortage of health care professionals to provide these services. The timelines are very tight, and they need to be, in order to keep costs down. To keep those timelines working well, you need to have a lot of providers available to provide the assessments and to provide the rehab. We're in agreement with that.

Assessments I think are critical from the standpoint that we do need to get a baseline measure. However, I think some sort of standardization for assessments would be very beneficial in terms of what it is that these assessments are actually looking for. That needs to be discussed with the health care providers. I've seen assessments that are a few pages, all the way to 30 or 40. So what's reasonable? That's what we need to come back to, because obviously the longer the assessment, the more time, and therefore the greater the cost. That's where we stand on some of those issues.

The Chair: We move to the NDP.

Mr Prue: Thank you. A minute and a half is not much, so my question is going to focus in on—you want the money to be put back. The kinesiologists used to get back to the pre-set levels; that is before they were tampered with last year. Is that pretty fair?

Ms Glenn: Yes.

Mr Prue: How much, on average, are kinesiologists losing vis-à-vis how much money they earned last year doing the same kind of work?

Ms Glenn: The average kinesiologist in our association was not being overpaid by any extent of the imagination. According to our last survey, the average kinesiologist was only making $30,000 to $35,000 a year. It's not excessive. The top end of the range with business owners, people who obviously have a lot more responsibility, probably would have been in the $75,000 to $100,000 range maximum, and that only represents about 1% of the total population of kinesiologists.

Mr Prue: Right. So if we went back, because this government is trying to, I think, save money for consumers—obviously you're asking that they spend a little more.

Ms Glenn: Yes. I'm asking that you—

Mr Prue: How much would it cost? Can you round it off—even a guesstimate—how many millions of dollars this might add to the system?

I'm not unsympathetic to what you're saying. I just want to know how much it would cost if you were recognized and got your funding back to pre-set levels.

Ms Glenn: I actually think it's not going to cost you anything, because what will happen ultimately is that you'll pay the kinesiologists to do their job. You'll see the cost savings come out, insurers paying less in income replacement benefits to injured parties, their requiring fewer services overall.

It's scientifically shown over and over again. The Institute for Work and Health certainly supports the position that early intervention through exercise therapy will drastically reduce the amount of time that people require to recover. So, instead of a person being off for three or four months collecting income replacement benefits, we're now looking at shortening that and having them off for a couple of months. That's where the cost savings come in.

The Chair: Mr Colle.

Mr Colle: There were some dramatic changes made to your profession by the previous government's Bill 198 and the regulations. Did you have an opportunity to make a submission to the hearings on Bill 198?

Ms Glenn: We weren't allowed to participate quite as fully as we had wanted to. We did make some submissions and we spoke with the individuals who were involved in those changes. I'm not trying to seem rude, but we felt that our concerns and issues fell on deaf ears.

Mr Colle: Were there any committee hearings on Bill 198 and the changes like there are for this bill?

Ms Glenn: Yes, there were some closed sort of committees.

Mr Colle: Closed—there were no committee hearings, as I understand.

Ms Glenn: They weren't legislative, no.

The Chair: Thank you for your presentation this morning.

ASSOCIATION OF DESIGNATED ASSESSMENT CENTRES

The Chair: I would call upon the Association of Designated Assessment Centres to come forward, please.

You have 15 minutes for your presentation, and you may wish to allow for questions. Please identify yourselves and your organization for the purposes of our record, Hansard.

Dr Rocco Guerriero: I'm Dr Guerriero, past president of the Association of Designated Assessment Centres.

Dr Carlan Stants: I feel like a poltergeist. I'm Dr Carlan Stants. I spoke to you earlier and I'm back.

1130

Dr Guerriero: I'd like to thank the standing committee members for allowing ADAC the opportunity to speak to you today with respect to Bill 5.

The Association of Designated Assessment Centres is a non-profit organization that consists of the majority of the designated assessment centres across Ontario. Presently, there are over 100 designated assessment centres. They represent approximately 3,000 health professionals. The centres are in hospitals and private health care facilities, and with other support staff they represent about 5,000 people.

The mission of ADAC was to ensure excellence in the quality of providing neutral assessments of injuries by applying evidence-based principles in determination of causation, disability, med rehab, attendant care needs and assessment of disability status.

We support the government's present and future initiatives in finding appropriate ways of saving costs to the consumers, but to achieve these savings by not discriminating against any particular sector in auto insurance.

Just to give you a historical perspective of the DAC system, it started in January 1994. Back then there was an assessment that was done by a health care practitioner. An insurer may have ordered an assessment, and the DAC system was meant to provide a second opinion—a third party neutral assessment. There are many different issues that come into dispute. It could be disputes over treatment, it could be disputes over disability or attendant care, and we are the arm's-length, third party centre to provide that function.

Throughout the auto insurance process we've been dealing with for the past few years, ADAC has led the way for change. ADAC, through Dr Carlan Stants, formed a coalition to provide a cohesive voice of health care providers to the government. When there was a problem with implementation of the standard invoice, we came up with a consensus and solutions to make the standard invoice better for health care providers and insurers.

It was ADAC that helped in the harmonization of OCF forms. These are forms that are used in auto insurance to help the insurance adjuster make a better decision and not necessarily run to ADAC for a dispute. We've improved the forms. We spent years with others in the health care community to change these forms. We participated in consensus-based discussions with the government, with lawyers, with FSCO and insurers to come up with solutions that led to Bill 198.

In the four major areas that we looked at in decreasing med rehab costs, we came up with a pre-approved framework. We came up with requests for assessments to control costs of assessments, and in doing so we needed to come up with a system that responds to these disputes quickly. So ADAC was the leader in designing a fast-track DAC system. This fast-track DAC system deals with disputes over a pre-approved framework, or disputes over an assessment that's requested by a health care practitioner. We also took the opportunity to reform the med rehab DAC process. We looked at the process and designed efficiencies. This is called the stage-focused process, which focuses on the area of the dispute and does it faster and cheaper.

We commissioned Deloitte Touche to do a focus review on the DAC system and look at operational analysis and financial analysis, to give us recommendations for improvement.

What is the value of the DAC system? As I mentioned earlier, it's a second opinion on medical issues. These are clinicians who provide their clinical opinion when there is a dispute about treatment, about disability. It's a neutral assessment process. Neither party decides who is going to do the assessment. In the previous legislation, it was sent to the closest DAC. Today it's either agreed by both parties or randomly selected by FSCO. So it's an arm's-length process; it's not selected by any particular party.

It's transparent. The reason that there are some procedures we have to follow is to increase transparency between both sides. It's an essential component to dispute resolution. The Deloitte Touche study recognizes that you need early dispute resolution. Whenever there's a statutory accident benefits schedule, you need dispute resolution so that people won't continue to request unnecessary treatment. We are the filters in the system who either approve good quality care or redirect care when we feel it's reasonable.

We abide by general guidelines and operational guidelines set by the Financial Services Commission of Ontario, by the ministry's committee on the DAC system, and we're also regulated by our individual professional colleges. We're a system of health care experts. Most of the people in the DAC system work at hospitals and teaching institutions and are respected peers in their individual professional associations.

We're regionally based across Ontario. We have DACs in northern Ontario, Ottawa, Toronto, Windsor and all over the province. We're accessible. We have to provide an assessment within two weeks of being presented with a file. Now with this new fast-track system, we have to assess the case and provide a response within five business days. It's timely. You can get a response for a normal dispute within 42 days of initiation of the process and, for the fast-track DAC process, you get a response within five business days.

They're cost-effective. The new fast-track process is cheaper than going to mediation. Like I said, it's a system that's based on impartial assessments. You have

evidence-based decisions, you have good consumer protection. With our quality management procedures, we have high satisfaction rates by consumers. It has saved Ontario consumers hundreds of millions of dollars in the past five to 10 years that you've had DACs. The way it does that, the statistics show, is that in med rehab, for example, one third of treatment plans are denied, one third are modified and one third are approved. So it protects the system against unnecessary or excessive treatments.

The DAC system was a linchpin to the development of Bill 198. In Bill 198, we designed these pre-approved frameworks, we designed this request for assessment, and you needed a fast-track system to deal with these disputes. That is why we came up with the fast-track DAC process.

You've heard of some statistics that some stakeholders have presented. Some of these stats are flawed and misrepresent the system. For example, the industry has presented numbers of assessments costing $180 million, $220 million, and now the figure is up to $300 million, and they blame everything on the DACs. DACs cost the system $45 million in the past year. Insurance examinations make up over $100 million, and there are other section 24 assessments that make up the bulk of the remainder. So unfortunately some of these statistics have been misrepresented to you and we wanted you to know what the facts are.

ADAC supports the work of the coalition in trying to find ways of saving costs in other parts of the system. We feel it's important that you have a neutral assessment system to answer disputes in a cost-effective and timely manner.

In conclusion, we remain committed to working with the government to maintain a neutral, arm's-length, expert peer review assessment system to ensure an appropriate balance between access to health care benefits and preventing excess in med rehab benefits.

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The Chair: We have time for about a minute per caucus.

Mr O'Toole: I've been pleased to meet you in the past few years when I did consultations on this issue. I'm hopeful there's some resolve to make it clear. I want to put on the record here, with the permission of my constituent, that Jacqueline Hurren, a constituent of mine, was in an accident on February 28, 2002. To date, she has had no resolve, an accident victim. She was hit by an impaired driver. I don't think it's a matter of fault, it's a matter of—she's been through what she says are unnecessary, needless and costly DACs and she's wondering why there is so much time and delay. Her accusation is there's a huge amount of delay in receiving treatment.

On speaking to people in the industry, this particular lawyer—I won't mention his name—says that some of the catastrophic impairment DACs cost as much as $60,000. I've met with you. I believe there has to be a clearing house. What solution will you bring to the table so that those providing treatment and those providing assessment are independent and indeed accountable to someone—the government, fiscal, whoever? That's really the problem here. I want the fast-track DACs and I want independence. We need a clearing house, we need a broker, and I understand that. How can you respond to that issue for the government?

Dr Guerriero: You hear anecdotal stories like this about cat-DACs costing—the majority of cat-DACs don't cost anywhere near that kind of amount. It's less than $20,000. I sit on the minister's committee and we've looked at these numbers. The cat-DAC assessment is very complex. The cat-DAC assessors have to look at the definition of a catastrophic impairment. You have to look at different levels and you have to have different medical specialists doing the assessments. That's a very minuscule amount of the assessment process. What we were going to do was to bring the model of the fast-track DAC process, the staged focus assessment to the other types of assessments and streamline those other types of assessments.

As for the timelines in receiving results, like I said, the new staged focus model attempts to achieve a more timely result in getting your reports because it deals with fewer assessors in a more timely manner. We've implemented quality management procedures to improve the timelines especially.

Mr Kormos: You guys have been taking a real beating. I don't know if it's justified or not. I mean, we had one dough-head in the Legislature just last week talk about a $25,000 DAC assessment to determine that a woman needed a front-hinging brazier. It's always a friend of a friend of a friend kind of story, right? It's like the abduction attempt that happens once a season, every time you talk about a mall or a plaza in small-town Ontario. It's those kinds of urban mythologies.

You talked about misrepresentation. Mr Smitherman was one of your critics before the election, wasn't he, before he became minister? Was he accurate in what he was saying about DACs being the source of all these high costs of premiums?

Dr Guerriero: Unfortunately, I never had an opportunity to speak to Mr Smitherman. I was away on holidays at that time. Sure, he was inaccurate with his numbers and the fact that we were the cause of the problem. These are—

Mr Kormos: Did he misrepresent the numbers?

Dr Guerriero: Pardon me?

Mr Kormos: Did he misrepresent the numbers?

The Chair: You've asked your question.

Mr Kormos: Well, I've just asked a supplementary.

Dr Guerriero: I just said the numbers are accurate as provided by FSCO. The represent $45 million. But we're the referee in the system. Nobody likes the referee. Taking the referee out of the game will cause chaos. It's ridiculous. People in the DAC system are the medical experts who provide opinions.

The Chair: Thank you, and we move to the government caucus. Mr Colle, very brief.

Mr Colle: The previous deputant mentioned this GTA gap on claims and the costs of medical claims being made. Since you have DACs right across Ontario, have you noticed this gap we talk about, where basically it seems to be a different culture of claims and opportunistic claimants in the GTA or the rest of Ontario? Does that exist, according to the DAC data that's kept?

Dr Guerriero: Could you elaborate on what you mean by this gap?

Mr Colle: Basically, you're saying there seem to be more claims proportionately—medical rehab etc—in the GTA than in the rest of Ontario. The consumers' association of Ontario made that presentation. In terms of the DACs in every part of Ontario, is there any difference that the DACs have noticed between the GTA—the level of claims, number of claims, the amount of DACing that takes place in the GTA as opposed to the rest of Ontario?

Dr Guerriero: I would estimate that there are more DAC assessments that take place in the GTA, just based on—there are more people in the GTA. We still see people in the outer regions of the province. What this is due to—this is why collecting data and having the right data is important, so you can make good policy.

The Chair: Thank you for your presentation this morning, gentlemen.

ONTARIO PHYSIOTHERAPY ASSOCIATION

The Chair: I would call on the Ontario Physiotherapy Association. Good morning. You have 15 minutes for your presentation. That can be made up of a presentation and questions if you so wish.

Ms Signe Holstein: My name is Signe Holstein. I'm representing the Ontario Physiotherapy Association. On behalf of the 4,500 physiotherapists across Ontario who are members of the association, I do want to thank you for an opportunity to speak to Bill 5. The time is short, so I intend to keep my remarks short.

Our members fully understand and sympathize with the motivations behind Bill 5. We all pay auto insurance premiums too and we understand the need to keep the spiralling costs of automobile premiums under control.

For those of you who are new to this subject, physiotherapy actually was the first organization to agree to a first-ever fee schedule and utilization guideline with the insurance industry, and did that back in 1996. We did this because we recognized the need to work together to develop solutions for the constituency that we both share, namely people who are injured in motor vehicle accidents.

Perhaps a measure such as Bill 5 is the necessary shock to the system, but perhaps there's no time to do anything else. Having said that, we do have misgivings about the unilateral approach. In the first place, physiotherapy, together with the health care professions that provide services in the motor vehicle accident stream have spent an enormous amount of time and resources over the last several years working with the insurance industry, developing a consensus, working with the government and other stakeholders to try to reach workable solutions to the problems that we all recognized in the system. The work resulted in a package of reforms that was announced by the previous government in July, and we think, in all honesty and good faith, that package would have addressed the issues, or at least would have gone a very long way to addressing those issues.

At a minimum, we think the package should have been given the opportunity to show what it could do, and we're more than open, as evidenced-based, best-practice practitioners, to look at evaluation and re-evaluation.

It was deeply regretted by us, therefore, when the previous government unilaterally announced a new fee schedule and other reforms on September 8. Unilateralism is not the way to get health care practitioners to throw their support behind an initiative, and health care practitioners' support is required if motor vehicle accident victims are to get the care they require when they require it.

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We also remember the impact of an analogous move 30 years ago by the federal government, namely wage and price controls. Wage and price controls created many structural anomalies throughout the supply chain. We are concerned that the same will happen under Bill 5. Those structural anomalies will impact disproportionately on health care practitioners who provide care to claimants, and will actually reduce motor vehicle accident victims' access to timely, quality and appropriate care.

The September 18 unilateral announcement by the previous government has already hit our profession very hard. Physiotherapists are expected to swallow a 30% reduction in the fees we can charge for treating motor vehicle accident victims. Over the past decade, health care practitioners have taken the brunt of periodic cost-cutting exercises, hospital downsizings and reorganizations, SARS and so on. Morale amongst physiotherapists is low, and many physiotherapists are feeling betrayed and hurt at this latest initiative. Despite that, they're struggling valiantly to provide the service that they believe the claimant requires.

Once Bill 5 is proclaimed, we urge this government to return to the path of developing consensus among insurers, health care practitioners, the government and other stakeholders in the motor vehicle accident system.

Moving to another issue, we urge this committee to propose an amendment to Bill 5. The amendment would mandate the establishment of an organization to collect, aggregate, analyze and publish data relating to the motor vehicle insurance industry. That organization could be part of FSCO, or could be somewhere else. It would have to be, however, a separate and independent body from the insurance industry.

This association has been pushing for such a capability since 1996, and we thought we had the agreement of the insurance industry to implement it. But it has never happened. As a consequence, we have the "dirty data" syndrome, where all stakeholders rely on data generated

by the insurers. It is beyond us how anyone can contemplate the development of regulations for an industry without having reliable and current data to work from. I'm sure you've heard comments time and again on the availability of good data to make these decisions.

Finally, we are concerned that Bill 5, in essence, caps premiums but provides no framework or direction as to how costs are to be cut. For example, we would like to see, even if only in a preamble, a statutory admonition that insurers must not cut costs in a way that impairs reasonable and fair access to necessary health care and other benefits. We are concerned that Bill 5, as written, essentially gives insurers carte blanche to do whatever they feel has to be done to cut costs. We are deeply concerned that the cost cutting will be done at the expense of service providers and their patients.

By way of example, we are concerned that insurers will put preferred provider regimes in place. Preferred provider regimes actually reduce access to health care and, in the long term, increase health care costs. We are concerned that insurers will, once again, begin to micromanage cases and interfere in critically important health care decisions.

The administrative burden health care practitioners already face in providing services in the MVA sector is enormous. Attached to the copies of our presentation that we have given to the committee clerk is a comparison of the administrative tasks health care practitioners must perform in the MVA sector and the WSIB and private patient streams. That was prepared by one of our clinicians, in terms of her regular activity within her practice. We think that comparison speaks for itself and we are deeply concerned that the absence of guidelines will only make the situation worse in terms of insurer micromanagement and interference in health care decisions.

We are concerned that more patient care will be pushed into the already overloaded publicly funded system. We are concerned about customized policies that could short-change policyholders when they need medical rehabilitation benefits. We are concerned that the insurers have already begun to abandon the evidence-based, profession-specific guidelines that were developed to guide practitioners and adjusters. We are concerned that insurers will progressively develop a "one size fits all" approach that stifles our ability to provide patient-centred care.

That concludes my formal remarks. I would welcome any questions or comments.

The Chair: Thank you very much. We have time for one question. Continuing with that rotation, we'll begin with the NDP and Mr Prue.

Mr Prue: One question then. I'd like to go back to what you have written in the last paragraph on the third page: "For example, we would like to see—even if only in a preamble—a statutory admonition that insurers must not cut costs in a way that impairs reasonable and fair access to necessary health care and other benefits. We are concerned that Bill 5, as written, essentially gives insurers a carte blanche to do whatever they feel has to be done to cut costs."

That's really what happened in October and November of this year; that's what's been done by the previous government. In terms of physiotherapists, what effect has this had and, if we go back to how much money you were perhaps making before this was done, how much will this cost to the system?

Ms Holstein: Will this cost to the system?

Mr Prue: I'm trying to empathetic, but I understand—I think you've been ripped off.

Ms Holstein: Yes, that would be fair. I think the problem we're having, and that a lot of us do have, is that it's difficult to quantify exactly where the money is being spent reasonably and fairly, because the data is not that clear at that point. We know that physiotherapists, yes, have had a 30% cut in the fee schedule that was set in 1996. That hasn't had an impact on practice. One of the concerns we have is that physiotherapists will move out of that sector and it will become more difficult for people to access care in the sector. Even within the sector, you will have to amend your practice to deal with the cuts and that may have an impact on the length of time. If someone is in the process it may have an impact on when they can access it. We know that pre-approved frameworks are built on early intervention, reassurance and return to usual activities as soon as possible. It's a key to getting these people back into their workplace, school and home. Anything that impacts negatively on that ability will increase costs in the long run.

The Chair: Thank you for your presentation this morning.

CANADIAN SOCIETY OF CHIROPRACTIC EVALUATORS

The Chair: I call on the Canadian Society of Chiropractic Evaluators.

Dr David Dos Santos: Good morning. May name is Dr David Dos Santos. I'm the president of the Canadian Society of Chiropractic Evaluators. Sitting next to me is Dr Rajwani. He's on the executive committee.

I'd like to start out by explaining a little bit about our organization and what we do. We're a not-for-profit, voluntary organization representing chiropractors who perform independent assessments and provide expertise to third-party payers, government agencies and the legal community in an expert capacity.

I'd like to congratulate this government on the introduction of Bill 5. We agree with the goals and initiatives of the government in attempting to stabilize auto insurance premiums and to also provide a framework for achieving further cost savings with further initiatives. We are also in agreement with the government's long-term initiative to evaluate the feasibility of allowing customized auto insurance plans.

I'd like to touch on the medical rehab sector for a minute. We feel that there are lots of different cost-drivers to the auto insurance system, and the problems in

auto insurance are not just in auto insurance, as you're well aware, but they're systemic to the whole insurance industry. One of the things that we've heard in the past is that med rehab is a major cost driver. With the introduction of Bill 198 there was an attempt to address some of these concerns. There were initiatives taken to address the cost of assessments. There were initiatives taken to the cost redundancy of assessments and also to achieve cost savings in med rehab with the introduction of pre-approved frameworks. We were fully in agreement with those.

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We will work with this government to achieve further cost savings, but we would like to point out that it shouldn't be solely on the backs of the med rehab sector. The other sectors have to be looked at at this point so that there is an equitable balance of cost savings throughout the system. At the same time, we encourage that injured claimants be allowed access to the health provider of their choice, at the same time allowing for a neutral, independent, third-party assessment system. To date, the DACs have fulfilled that role. We encourage that there be maintenance of some independent referee within the system.

You've heard from some of the other groups that have spoken this morning about the fee schedule and the imposition during the last election. We would concur with some of the comments made, that it was passed in the midst of an election without any sort of consensus-based or collaborative process. The fee schedules that were in place prior to that were brought in in 1996. They were brought about through negotiations with the insurance industry. There's been no change to the fee schedules since 1996. There's been no increase in rates.

The last point I would like to touch on is the critical need for valid and reliable data so that any future policy decisions are based on accurate numbers, so that there can be sound policy that is put in place for development of any future legislation.

The Chair: Thank you very much for your presentation. We have about three minutes per caucus. We start with the official opposition.

Mr Barrett: You indicate that 70% of total savings are coming from the medical sector or the rehabilitation sector. You've identified tort as a significant cost driver. Working with the industry, within the industry, with the companies, what other suggestions would you have for insurance companies to achieve savings in their way of doing business, their administration?

Dr Dos Santos: Working within the system, we do see inefficiencies with the insurance carriers. We see that there could probably be better ways of claims handling. There may be other areas that could be looked at. Transportation costs have been one area the insurance carriers have expressed as a potential cost driver. Perhaps as a by-product of the introduction of the pre-approved frameworks, there could be some reduction in allowance for transportation costs, things like that.

Mr Barrett: We understand the number of accidents has been falling, but premiums are going up. Any further comment on why this is occurring?

Dr Dos Santos: My understanding is that there was a change in how that was derived. I believe there was a re-setting of the actual amount of what would constitute an accident as far as vehicle damage is concerned. That may affect some of the statistics.

The Chair: Mr Prue for the NDP.

Mr Prue: You are saying much of what has been said by previous witnesses: the health care professionals are bearing the brunt of any cost reductions, savings to the system in the last year or so. I asked them whether or not there would be long-term savings if they were allowed to go back to the former fee schedule and simply do their jobs right. Are you of the same view?

Dr Moez Rajwani: One of the major changes that Bill 198 made was the pre-approved frameworks. A lot of the increased cost in health care benefits were happening in uncomplicated type injuries in the first few weeks. I think that was appropriately addressed with the pre-approved frameworks with set fees. The challenge became, after the pre-approved frameworks were established in a consensus-building mode, there was a fee schedule imposed after the fact, which actually reduced the fees of the pre-approved framework along with hourly rates. I think that health care professionals who agreed with the pre-approved framework would have been able to work within that framework and provide cost-effective and appropriate health care to bring injured patients back to their pre-accident level. It was the second restraint that really challenged everybody in their environment, because the first was based on consensus, with the coalition working together with that, and the second came in an arbitrary manner. If we had kept with the original mandate of the pre-approved framework, I think you would have seen cost savings with the original fee schedule.

Dr Dos Santos: The other thing I'd like to point out is that one of the issues the insurance industry raised was that the major cost driver within the med rehab sector was the cost of assessments. Under section 24 of the previous act, the insurer was required to pay for all reasonable assessments. There were no checks and balances, or there were very limited checks and balances. Now, the introduction of the fast-track axe is a cheap way of screening for whether the assessments are reasonable, and we anticipate it will achieve cost savings in that area.

The Chair: Thank you. We'll move to the government caucus.

Mr Colle: One of the things that's perplexing a lot of people in this whole area of auto insurance and medical benefits and coverage is, if I hurt my neck coming out of my house, I go to the family doctor or to the hospital and it's covered by OHIP, right?

Dr Dos Santos: Partially covered.

Mr Colle: Or I can go to the chiropractor, right?

Dr Dos Santos: Or a physiotherapist.

Mr Colle: But I go through OHIP; I can't go into the auto insurance medical system. If I hurt my neck in a car, then I go into the auto insurance medical system, right?

Dr Dos Santos: Right.

Mr Colle: And there's a different rate. So if I hurt my neck in a car, what's the charge for the treatment a professional would give?

Dr Rajwani: Just to clarify that, if you are in car accident, you would still go to your family doctor, who would assess you through the OHIP system. The added cost the family physician may charge you is for the paperwork that is involved in terms of filling out forms etc. They would then refer the person, just like when you slip and hurt your neck at home, to a physiotherapist or a chiropractor, and there are both systems. There's an extended health care system, where a physiotherapist or chiropractor would treat through a private system, and there's partial coverage by OHIP for chiropractors and in hospital settings and with certain OHIP clinics for physiotherapy. So even slipping and hurting yourself at home or straining your neck is not fully covered by OHIP. There's partial coverage through OHIP. If you require extensive services, patients either pay from their pocket or their employer benefits may cover—

Mr Colle: What if they don't have any money in their pocket and don't have insurance at work? They still have to pay for it through OHIP basically. They get what OHIP gives them.

Dr Rajwani: Yes, they do.

Mr Colle: Then we have a third type of health care system. If you get hurt at work, you have a third health care provider system under WSIB, right?

Dr Rajwani: Correct.

Mr Colle: Another rate scale. So you've got three different charges at three different levels for what might be the same injury, but depending on where you get hurt, a different fee kicks in.

Dr Dos Santos: The numbers with those fee schedules are somewhat misleading. Our professional fee guideline does not account for charging per hour, and the fee schedule that's been imposed in the last election was an hourly rate. Basically, most health care professionals charge per service. So it's somewhat misleading to look at a comparative number.

Mr Colle: But I'm just saying it could be the same injury—

The Chair: Mr Colle, your time has expired.

I want to thank you for your presentation this morning, and to all presenters in the room, thank you for your presentations.

For the committee's notice, our first presenter will be in at 4 o'clock this afternoon, and I would ask you to arrive promptly. This committee is recessed until 4 o'clock.

The committee recessed from 1209 to 1602.

The Chair: The standing committee on finance and economic affairs will come to order.

Mr Kormos: Quorum.

The Chair: A quorum is not present. I would ask for a recess.

The committee awaited a quorum.

The Chair: Members of the committee, not seeing a quorum, I will have to adjourn the meeting.

The committee adjourned at 1607.

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