Addressing Psychological Impairments Without Altering the Existing SABS: A Blueprint for Equitable Access to Benefits

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INTRODUCTION

Thank you for the opportunity to provide these comments on behalf of the Ontario Psychological Association (OPA). As psychological health practitioners, who provide assessment, treatment and rehabilitation as well as Insurer Examinations (IEs), we have a comprehensive and evidence-informed perspective on the SABS. We are particularly focused on the need to correct insurers' unfair denial of benefits for accident victims with psychological impairments including MTBI/concussion. (For the purposes of this paper, the terms "injury" and "injuries" have the same meaning as "impairment" and "impairments" respectively as used in the SABS. The term psychological disorder is also used interchangeably with psychological injury and psychological impairment).

The 2023 Budget describes the government's goals for auto insurance. Fairness is a key objective in the government's plan to fix auto insurance. The budget also states:

> *The government is taking action to make auto insurance more affordable. The government will continue to make progress on previous commitments, including cracking down on fraud and abuse and considering options to provide more choice, reduce disputes and improve health access and outcomes for people.*

In this document we provide background information, describe current problems, and provide solutions to make the auto insurance system work better to achieve the government's goals <u>without changing the current SABS:</u>
Fairness, for accident victims with psychological impairments;
Reduce disputes, improve health care access and outcomes for all accident victims;
Choice;
Control cost;
Crack down on organized crime, auto theft, and fraud.

In this submission we first focus on two of the government's goals: <u>fairness</u>, particularly regarding fair access to benefits for accident victims with psychological impairments; and <u>reducing disputes and improving health care access</u>. We provide background information, describe current problems, and provide solutions to make the auto insurance system work better to achieve the government's goals <u>without changing the current SABS.</u> We then address the government's other goals. Our solutions do not require any changes to the SABS.

KEY MESSAGES

Solutions without changing the current SABS

- There are solutions to make the auto insurance system work better to achieve the government's goals without changing the current SABS;

Fair access to benefits for accident victims with psychological impairments

- Fairness requires eliminating unfair and discriminatory insurer denials of benefits for accident victims, especially for those with psychological impairments, including brain injuries.
- The monitoring and enforcement described in the FSRA supervision plan are essential to changing insurer claims management behaviour to make the SABS work more effectively. OPA will provide case books of problematic insurer claims management for risk based follow up;
- Psychological impairments are not minor injuries. They are a significant cause of disability and have significant need for individualized and specialized care to reduce impairments and restore function.
- Insurers' unfair denials demonstrate a lack of knowledge regarding psychological impairments, stigma, and discrimination. All insurance companies must be required to confirm their adjusters have a basic level of education and training to fairly review applications for accident victims with psychological impairments. OPA will work with others to develop training materials.
- The minor injury definition and minor injury guideline (MIG) are clear, internally coherent, and are being successfully applied to the majority of accident victims. They should not be amended to include psychosocial issues or psychological disorders in the definition, and psychological treatment should not be added to the MIG;
- It is unfair to accident victims with psychological impairments for insurers to deny treatment plans by incorrectly asserting the psychological impairment is a minor injury. As described above, psychological impairments are not minor injuries. It must be clarified that this type of denial fails to meet the insurers' obligation to provide "medical or other reasons". Therefore, the proposed services may be provided until a complete response is received;
- Accident victims with psychological impairments face additional barriers, delays and denials of initial assessments to plan treatment. Denial of an initial assessment is a defacto denial of treatment. Enforcement of fair insurer review of applications for assessments to plan for treatment is required for timely access to improve health outcomes.
- Fairness precludes allowing an option to reduce premiums in exchange for being restricted to the Insurer's Preferred Health Provider Network (Insurer's PPN). An insurer's PPN has inherent conflict of interest. Being restricted to the insurer's PPN would undermine the accident victim's ability to have the necessary trust in their treating psychologist. It should not be allowed.

Reduce disputes, improve health access and outcomes for all accident victims

- Insurers' review processes lack communication and transparency. Insurers do not give the accident victim or the proposing health professional a reasonable opportunity to respond to any questions when they review an OCF 18. Instead they deny the benefit.
- Insurers' denials do not include specific "medical or other reasons" and lack a specific explanation of why a benefit is not reasonable and necessary: denials often simply state either

"medical or other reasons" or "not reasonable and necessary". Enforcement of the insurer's obligation to transparently explain the reason for a denial is needed. FSRA guidance should confirm the accident victim may proceed with the proposed services until a response that includes explicit reasons is received.

- Disputes often are the result of insurer's unfair addition or changes to the criteria for approving assessment and treatment plans, such as requiring that proposed services be "essential" or requiring "compelling evidence". These unilateral changes to the criteria by the insurer create an unfair and higher bar for approving the proposed services than SABS criteria of "reasonable and necessary". This is a systemic issue that requires FSRA supervision, not individual dispute resolution.
- Insurers deny or reduce specific services in an assessment or treatment plan (that is, they give a "partial approval") without providing specific reasons. These partial approvals are often de facto denial of the services. It is clinically unsound to provide the services to patients that have been drastically reduced by the adjuster. Evaluation of the specific patterns of partial approvals by insurance company is required for risk based follow-up by FSRA.
- Insurers have commented that they do not have sufficient information to make informed claims decisions and therefore request additional information or use this as justification to require an IE which causes unnecessary delays and IE costs. To address any information gap, FSRA should immediately initiate a multi stakeholder process to improve communication between proposing health professionals and adjusters as well as to update the OCF 18;
- HCAI must produce more robust reports, better utilizing the wealth of available information. More comprehensive and accessible data reports are needed to provide relevant system data including patterns of insurer denials.
- Systemic issues and insurance company policies are more appropriately addressed at a system level than by requiring individual disputes. Examples include: non payment of HST in addition to the PSG rate; company policies on non payment for certain activities; routinely requiring provider confirmation sign back forms.

Choice

- Creating additional optional benefits at this time would add complexity and confusion and create further disputes, with no assurance of significantly reducing costs and premiums. There also should be no reductions in the standard policy limits. Any options introduced should be to enhance the current policy amounts.

Cost Control

- The cost of auto insurance premiums is an ongoing focus of attention. Given the relatively small and decreasing percentage of costs of med/rehab benefits compared with other cost drivers, even removing these benefits entirely would not create significant savings. However, the large and growing costs due to organized crime, auto theft, and auto body repair must be addressed as the primary cost drivers in the system.

Crack down on organized crime, auto theft, and fraud

- The explosion in organized crime and auto theft creates untenable costs. It also is a source of harm to the public in the form of staged accidents and car jackings. We fully support the government's initiatives which have led to more effective utilization of data to identify fraud and crime and utilization of multi-jurisdictional anti-crime initiatives.

FAIR ACCESS TO BENEFITS FOR ACCIDENT VICTIMS WITH PSYCHOLOGICAL IMPAIRMENTS

Background

Much of the recent discussion of fairness has focused on premium rate determination and removal of postal codes as a criteria. The OPA supports processes to determine fair and transparent risk rating and premium determination. However, this is only a part of providing fairness for consumers. Fairness requires fixing unfair and discriminatory insurer denials of benefits for accident victims, especially for those with psychological impairments, including brain injuries.

The Insurance Act and the SABS include mental and psychological impairments, as well as physical injuries. Accident victims with psychological impairments are entitled to fair consideration of their applications for care. When insurers fairly apply the SABS, accident victims with mental and psychological impairments have timely access to the care they require for positive health outcomes. However, insurers fail consumers with discriminatory and unfair denials.

Problems: current barriers faced by accident victims with psychological disorders

LACK OF EFFECTIVE MONITORING, SUPERVISION, AND ENFORCEMENT TO ENSURE FAIR CLAIMS PROCESSING BY INSURERS

The SABS is a first party accident benefits system intended to provide timely access to care.

Accident victims with psychological impairments become vulnerable consumers and are dependent upon their insurer to fairly consider their applications for care. At the present time, there is not sufficient enforcement of the insurers' obligation to treat vulnerable consumers fairly and to provide timely access to care. When the insurer fails to meet their obligations and unfairly denies a benefit, the denial must be addressed by the individual accident victim through the complaint or dispute resolution processes, while access to treatment is put on hold. This process is often not timely or realistic for accident victims whose psychological impairments make these processes even more challenging. There is no mechanism to document, correct, and prevent these unfair insurer behaviours on a systemic basis rather than as individual disputes, and such a mechanism is necessary. Also, effective monitoring, supervision, and enforcement of insurers' compliance with the SABS is essential.

INSURERS' LACK OF KNOWLEDGE REGARDING PSYCHOLOGICAL IMPAIRMENTS

Psychological impairments are not minor injuries. Insurers' unfair denials of applications demonstrate a lack of knowledge regarding psychological impairments and mistakenly view them as less serious than physical disorders. There is also an incorrect assumption that unless there is a serious physical injury there cannot be a psychological impairment resulting from the accident. The reality of psychological

impairments, the need for access to proper care, and the significant disability burden they cause has been confirmed in health research and is reflected in current social and health policy.

According to the Diagnostic and Statistical Manual of Mental Disorders, DSM-5-TR, the authoritative classification manual,

> *A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.*

Dr. Cote's extensive research on Common Traffic Injuries (CTI) makes it clear that psychological disorders should not be classified as "minor," as they are more serious injuries that create disability and require specialized care (note: To avoid the problems associated with calling a person's injuries "minor" or "not minor," Dr. Cote adopted the terminology Type I and Type II injuries). His report concludes,

> *Type II injuries typically involve a substantial loss of anatomical alignment, structural integrity, psychological, cognitive, and/or physiological functioning. The majority of patients with such injuries will require (in addition to natural healing) a significant amount of medical, surgical, rehabilitation, and/or psychiatric/psychological intervention to ensure an optimal recovery. There is an evidentiary basis for major concern about both the extent of recovery and about the likelihood of complications developing and/or persisting in the absence of such expert care; significant impairment and disability are primary concerns. Examples of traffic collision-induced Type II injuries include fractures of the femur and hip, shoulder dislocation/fracture, facial fractures, depression or post-traumatic stress disorder...*

These descriptions highlight the reality that psychological impairments are significant and not minor. They are a significant cause of disability and result in significant need for individualized and specialized care to achieve the restorative purpose of auto insurance to reduce impairments and restore function.

Adjusters are given significant power to approve or deny applications for assessment or treatment of psychological disorders without a requirement to demonstrate sufficient education or training to be able to make informed decisions. It is irresponsible to give the adjuster this power without ensuring they have sufficient knowledge to make these decisions. Denial and obtaining an IE is often the default approach, without appreciation of the harm and costs of the denial even if the application is subsequently approved subsequent to the IE.

DISCRIMINATORY ATTITUDES, BELIEFS AND BEHAVIOURS TOWARD ACCIDENT VICTIMS WITH PSYCHOLOGICAL IMPAIRMENTS

The lack of accurate knowledge regarding psychological impairments allows decision making to be based on stereotypes that reflect stigma and discrimination. As such, accident victims making claims for treatment of psychological impairments are unfairly presumed to be exaggerating or falsely claiming to have a psychological impairment. This lack of knowledge also results in accident victims being unfairly subjected to additional barriers and requirements. Because of this, they are also met with excessive and unfair denials.

Accident victims may be unfairly required to provide “compelling evidence” of a psychological impairment when applying for approval for an assessment to plan treatment. The determination of “compelling evidence” of psychological impairment often requires the completion of the very assessment that the insurer is denying. This pre-condition for consideration of the application, is not in the SABS, and is often an impossible requirement for the accident victim to satisfy without undergoing a psychological assessment such as the one that is proposed.

In our society it is often very difficult for patients to acknowledge that they have a psychological impairment and ask for help. Social attitudes continue to inappropriately reinforce that a psychological impairment is a sign of weakness and it can be overcome by strength of will. Because of this, it is a significant step for an accident victim to acknowledge the need for help to recover from a psychological impairment. As such, the experience of being denied by their own insurer and needing to “prove” that they have a psychological impairment makes some accident victims give up on seeking care. They experience the denial as a betrayal and breach of the trust they had in their insurer. Many patients with mood disorders, anxiety disorders, post traumatic stress disorders, and brain injuries have neither the capacity nor the resources to dispute the insurer’s unfair denial. To go forward to seek care they must dispute the insurer’s unfair denial and enter into an adversarial process with their insurer. In addition to precluding or delaying care, this harms the accident victim and interferes with recovery outcomes, fuels disputes, and adds costs.

THE MINOR INJURY DEFINITION AND THE MINOR INJURY GUIDELINE (MIG) ARE MISUSED TO UNFAIRLY DENY CARE FOR ACCIDENT VICTIMS WITH PSYCHOLOGICAL IMPAIRMENTS

The current minor injury definition and the MIG are not the problem and do not need to be changed.

The definition and guideline are clear, internally coherent, and are being successfully applied to the majority of accident victims. The SABS state,

> *“minor injury” means one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury; (“blessure légère”).*

There is clinical consistency in the types of treatments and MIG providers required; intensity; duration; and the onset and recovery course of these injuries. The inclusion of “clinically associated sequelae” supports addressing issues that are incidental to treating the minor physical injury, and these issues are assumed also to be minor and not disorders.

The SABS also establishes a minor injury “hard cap” benefit threshold of $3,500. This is approximately 5% of the standard benefit level of $65,000. Funding of other benefits, such as attendant care and in home assessments, are also precluded for those with “minor injuries”.

The MIG outlines a standardized, time limited (12 week) program of care for accident victims with “minor injuries” and a pre-approved $2200 fee. The MIG also includes an additional $400 for supplementary goods and services that can be provided by the MIG physical treatment practitioner, or other health professionals, to address incidental issues in the context of providing care to the “minor injury” including “psychosocial issues”. These transient psychosocial issues, which do not interfere with functioning and may be incidental to a minor physical injury, are not the same as psychological impairments.

In spite of the clarity of the minor injury definition and the MIG description, they are frequently misused by insurers to unfairly deny applications for assessment and treatment of accident victims with psychological impairments. The insurer denials incorrectly state, "the diagnosis indicates a minor injury and care is limited to the MIG". As was stated in the Taksali and Aviva, October 26, 2022 LAT decision,

> *[48] Also, merely naming the minor injury guideline as a 'reason' for denial is problematic. Firstly, the reason is circular. In essence, what this is communicating is that the insured is in the MIG because the insured is in the MIG. Secondly, it is not clear to the unsophisticated person is as to what specific medical condition this refers to.*

The solution to is to stop the insurers' unfair denials due to misuse of the minor injury definition and the MIG, not to amend the definition or the MIG as has been proposed by some stakeholders. Any changes, even if intended to provide clarification, would create complexity, confusion, and disputes. Such changes are not necessary. Any blurring of the distinction between minor injuries and psychological impairments suggested in some proposals is scientifically wrong, false, and misleading. Explicitly adding "psychosocial issues" to the minor injury definition, or adding "treatment by a psychologist" to the MIG would blur the distinction. For example, including "treatment by a psychologist" assumes there is a psychological disorder rather than a minor psychosocial issue. These changes are unnecessary and would be misused to unfairly reinforce the false assertion that psychological impairments are minor injuries and are to be treated within the MIG.

There are some who argue that to address potential fraud, it is necessary to include psychological impairments in the minor injury definition to address the risk of accident victims falsely claiming a psychological impairment to "escape the MIG". It is profoundly unjust to arbitrarily and incorrectly restrict an entire injury group of accident victims with psychological disorders that are beyond simple psychosocial issues to the minor injury category in order to to address allegations that some individuals may potentially be making false or inflated claims. There is also no indication that this is actually a significant issue or cost.

SPECIFIC PROBLEMS ASSOCIATED WITH DENIAL OF INITIAL ASSESSMENTS TO PLAN CARE

An application to the insurer for prior approval is required for assessments. When the SABS application and insurer approval process are fairly applied, accident victims with psychological impairments are able to access care in a reasonable, direct. and timely manner. However, accident victims with psychological impairments face unfair additional barriers, delays and denials to their applications for initial assessment to plan treatment. These delays are especially problematic given the research that documents the need for timely care for the recovery of the individual patient which also reduces costs to the system.

Reclassification of psychological impairments as minor injuries would be unscientific, discriminatory, and harmful because they do not have the same characteristics or care needs as minor injuries. The solution is to enforce fair insurer review of applications for assessment and treatment of accident victims with psychological impairments. There is no need to change the SABS minor injury definition nor the MIG.

To complete the OCF 18 application for funding of a proposed assessment, the treating psychologist of the patient's choice must gather clinical information from the patient. In a sense, this is a "pre-

assessment," since the treating psychologist must determine that there is a basis to certify that an assessment to plan treatment is reasonable and necessary. Further, the application process creates a challenging situation for the patient since they must discuss highly personal and often distressing information without any assurance that they will be able to proceed to assessment and treatment. It also involves significant time and financial risk on the part of the psychologist since there is no payment for this time if the application is not approved. Within the current process, it is actually in the interest of the treating psychologist and the accident victim to only engage in this process and prepare applications for assessment when there is clearly indication that there is a psychological impairment requiring treatment. Therefore, insurers should have a high level of confidence that applications can be presumed to be reasonable and necessary unless they have a specific "medical or other reason" to the contrary.

The assessment by the accident victim's chosen psychologist is necessary to determine if there is a psychological impairment and if it is a result of the auto accident. The assessment is also necessary to gather information regarding functional limitations; determine the most effective, evidence informed, course of treatment, (considering patient variables and preferences); and gather informed consent for the proposed treatment services and costs. Psychological assessments require significantly more time to conduct than assessments to plan treatment of most physical impairments. Without this assessment, no treatment can be proposed. An insurer's denial of funding for an assessment, is defacto, denial of treatment.

The obligation of insurers to fairly consider applications for assessment is reinforced in the Taksali and Aviva LAT decision, October 26, 2022,

> *To receive payment for a treatment and assessment plan under s. 15 and 16 of the Schedule, the applicant bears the burden of demonstrating on a balance of probabilities that the benefit is reasonable and necessary as a result of the accident. To do so, the applicant should identify the goals of treatment, how the goals would be met to a reasonable degree and that the overall costs of achieving them are reasonable. Notably, for an applicant to prove that an assessment is reasonable and necessary, it is not crucial for the applicant to prove the actual existence of a condition; rather, the applicant must prove that there is some objective evidence to suggest that some condition exists and warrants investigation via an assessment.*

The need for fair consideration of applications for assessment of psychological impairments is also reinforced in the Manjuladevi Rathakrishnan Applicant and Aviva Insurance Company LAT decision which concluded,

> *I find that it is reasonable and necessary for the applicant to be able to be assessed by Ms. Wagner in order to determine what, if any, treatment she requires as a result of the accident. While there is a question as to whether the applicant's psychological difficulties still 2023 CanLII 50585 (ON LAT) Page 9 of 14 stem at least in part from the accident, I find that it is reasonable for the applicant to explore whether that is the case. Further, clearly the respondent felt that an assessment was reasonable and necessary as it was content to pay for two with its own chosen assessors. It cannot be said that an assessment is only warranted when completed by an insurer's chosen assessor.*

In spite of the rigorous up-front application process and the LAT's confirmation of the expectation for fair and reasonable insurer decision making, there continue to be frequent, unfair insurer denials of assessments to plan treatment for patients with psychological impairments. At best, the unfair insurer denials delay care, create disputes, and add costs to the process. The unfair insurer denials often entirely derail access to care needed for the recovery process.

FAIRNESS PRECLUDES ALLOWING AN OPTION TO REDUCE PREMIUMS IN EXCHANGE FOR AGREEMENT TO BE RESTRICTED TO THE INSURER'S PPN

A patient's choice of treating psychologist at time of injury is critical for effective recovery from psychological impairments, and this freedom to choose is allowed in the SABS. Assessment and treatment of psychological impairments requires the patient to disclose and explore highly sensitive and distressing thoughts, feelings and behaviours. Patients must trust their treating psychologist to be open to this process. The ability to choose a treating psychologist is a cornerstone of this trust, and empirical data support that this choice is essential to good outcomes in treatment.

In addition, the accident benefit system requires that accident victims are able to rely on their treating health professionals to submit applications for further treatment, disability certificates, and applications for other benefits. They must trust that their treating health professionals can focus fairly on their needs and not be conflicted about maintaining their status as a preferred provider.

Proposals to allow the insurer to offer the option of a reduced premium in exchange for agreement to be restricted to the insurer's Preferred Provider Network (PPN) are completely incompatible with this foundational need for trust in empirically supported treatment. The inherent conflict of interest between the treating health professional's obligation for the welfare of the patient and their self interest in maintaining their status as a preferred provider undermines necessary trust in the treatment relationship.

The differences between the current situation wherein insurers may offer voluntary utilization of their PPN and a restricted or locked- in model are profound. The proposal to offer a reduced premium in exchange for being restricted to the insurer's preferred provider network (Insurer's PPN) is inherently unfair as informed choice is not possible. It is not possible for consumers purchasing insurance to know what health professional(s) they will require for their care if injured. It is not possible for the consumer: to anticipate that they will be injured; to know what injuries they will have; what treatment, rehabilitation and other benefits they will require; the duration of their impairments; and what costs will be. Therefore, it is not reasonable to ask the consumer to agree to limit their choice of health professionals at the time of purchase of their auto insurance. The SABS also describes the requirements for consumer protection when insurers offer voluntary use of their PPNs to injured claimants. (See Appendix A: SABS section 46).

In addition, restricted insurer PPNs would profoundly disrupt the "circle of care" required for effective health care. It is not possible for a health professional who wants to recommend another type of health service for their patient to know which health professionals are on which insurer's rosters. It also interferes with health care to be limited to the accident victim's specific insurer's PPN which may not include the specific health professional(s) who are most appropriate for the individual patient.

PPNs are actually unnecessary. It is important to acknowledge that the licensing of health professionals who are able to bill the auto insurer already provides a FSRA vetted network of health professionals. The FSRA licensing process includes criminal background checks and confirms good standing with health professional regulatory bodies. It provides a mechanism for addressing business practices and can impose penalties and remove licenses. Health professional fees are also already limited by the Professional Services Guideline. The SABS require submission through HCAI of standardized OCF 18 assessment and treatment plan forms for insurer prior approval and OCF 21s for invoicing. These provisions address many of the efficiencies and quality control elements that are often cited as benefits of a PPN.

Solutions

EFFECTIVE FSRA SUPERVISION OF INSURERS' "POLICY SERVICING"

FSRA has recently announced the Automobile Insurance Supervision Plan 2023-2025. This initiative suggests more focused attention on supervision of insurer including claims processing. The monitoring and enforcement described in the supervision plan are essential to changing insurer behaviour to make the SABS work more effectively.

FSRA has recently announced the Automobile Insurance Supervision Plan 2023-2025 which states,

> *Automobile insurance conduct supervision helps to ensure vehicle owners and lessees are treated fairly, from obtaining coverage through to making claims... Being physically present is among the most effective methods for understanding and confirming the operations of an insurance company, making on-site examinations a critical conduct tool. As a result, a risk-based approach was developed to prioritize examining the activities of insurers representing the highest risk to customers. Those activities include sales and distribution, underwriting, and policy servicing and will form the core of FSRA's conduct supervision programs in automobile insurance over the fifteen-month period beginning January 2024.*

The announcement also describes,

> *Claims - In the event a policyholder suffers a loss during the term of the policy, an accident report is submitted that starts the claims process. A fair and transparent claims handling process is a key element in customer protection.*

The supervision plan has potential to make a significant difference to identify and remediate systemic issues that harm accident victims. The supervision document includes the following promise,

> *FSRA will review insurers' claims handling processes to ensure claims are processed in a timely, fair, and transparent manner.*

For the goals of the Automobile Insurance Supervision Plan to be realized, FSRA must take timely and concrete action. Psychologists are aware of frequent insurer denials of applications that are not fair, transparent, or timely for accident victims with psychological impairments. However, there has not been an accessible, effective mechanism to address these unfair practices on a systemic basis. FSRA supervision of claims handling may provide a much needed opportunity for a remedy to correct these unfair insurer practices. The OPA will collate a case book of examples regarding problematic claims handling to illustrate patterns for risk-based follow-up by FSRA.

The FSRA supervision document also discusses FSRA's commitment to address the complaint process. It will be very helpful to compare the number of complaints, types of issues, how various insurers handle complaints, and consumer satisfaction with complaint resolution by insurer.

> *Complaints – Insurers are required to implement complaints handling protocols which are communicated to policyholders. Rejected or denied claims are common reasons for policyholder complaints against insurers. FSRA will review the number and type of complaints against insurers, as well as how they were resolved, as an indicator of the nature and quality of insurers' business conduct.*

In addition, it is critical to gather information to identify and remove barriers that discourage accident victims with psychological impairments from making complaints about unfair insurer denials. The OPA

will also collate a case book of examples of consumers who experienced unfair insurer claims handling but who have not made formal complaints. Psychologists are often told by their patients: “there is no point”; “I am afraid of backlash and making the situation worse”; or “I do not have the time, resources, knowledge or energy”.

As psychological health service providers, who bill auto insurers for services to accident victims, we have experienced the requirements of FSRA licensing including: initial application; screening, such as confirmation of standing with the professional regulatory body and police background checks; annual review; documentation; annual fee; as well as on site examinations and audits. These are powerful tools to provide quality control and ensure compliance with regulations. Utilization of these same tools with insurers should also have an impact on insurer behaviour.

REQUIRE INSURERS TO CONFIRM THEIR CLAIMS ADJUSTERS HAVE BASIC KNOWLEDGE OF PSYCHOLOGICAL IMPAIRMENTS TO REVIEW THESE APPLICATIONS

All insurance companies must be required to confirm their adjusters have a basic level of education and training to fairly review applications for accident victims with psychological impairments, including brain injuries. This requirement should be introduced within the next six months. We note that all work places are expected to ensure and document that their workers have appropriate skills and knowledge. Some examples include privacy, harassment, accommodations for disability. Similarly, FSRA requires each licensed health facility to complete annual documentation and confirmation of the status of the clinicians working in the facility.

The OPA is available to work with FSRA, Ministry of Finance, government, insurers, other health professional and consumer organizations, and educational institutions to identify or develop education and training programs. This approach has been successfully employed in other contexts to improve understanding and practices, as well as reduce disputes. The education regarding psychological impairments and MTBI/concussion, their treatment, and rehabilitation, could be made available to insurers and other parties.

CHANGING DISCRIMINATORY ATTITUDES, BELIEFS, AND BEHAVIOURS TOWARD ACCIDENT VICTIMS WITH PSYCHOLOGICAL IMPAIRMENTS

Insurer denials often reflect discriminatory beliefs and attitudes towards accident victims with psychological impairments. They appear to treat these accident victims with a high degree of suspicion regarding their honesty. This discrimination based on the type of impairment, psychological rather than physical, must be addressed as vigorously as other types of discrimination.

Anti-discrimination training that focuses on accurate knowledge of psychological impairments and fair treatment of accident victims with these disorders must be included in the training and supervision of those who have power to approve or deny their claims. When appropriately delivered, anti-discrimination training reduces stigma and discrimination and results in behavioural change.

SOLUTIONS FOR PROBLEMS ASSOCIATED WITH MISUSE OF THE MINOR INJURY DEFINITION AND UNFAIR DENIAL OF INITIAL ASSESSMENTS TO PLAN CARE

FSRA Guidance is urgently required to address the significant problems caused by unfair insurer denials which falsely assert that psychological impairments, (for example, mood disorders, anxiety disorders, PTSD) are minor injuries to be treated within the MIG. The educational requirements described above regarding the seriousness of psychological impairments are essential to correct any misunderstanding. In addition, the SABS requirements must be enforced. These unfair denials do not provide specific information to explain the insurer's assertion that the accident victim does not have a psychological impairment or that the impairment is not a result of the MVA. The denials only falsely assert that the, "diagnosis (of a psychological impairment) indicates a minor injury".

FSRA must issue Guidance that a denial which relies on the unfair assertion that the psychological impairment is a minor injury, fails to include a proper "medical or other reason". The Guidance must clarify that this unfair insurer claims handling practice does not meet the obligation to provide a complete and timely response. The services may be provided until a response that includes the specific medical or other reason is provided.

DO NOT ALLOW AN OPTION TO REDUCE PREMIUMS BY AGREEING TO BE RESTRICTED TO THE INSURER'S PPN

Maintain the current system which allows insurers to offer use to their PPN at time of injury and protect the injured person's right to choose alternative providers who are not in the insurer's PPN with no negative consequences.

REDUCE DISPUTES, IMPROVE HEALTH ACCESS AND OUTCOMES FOR ALL ACCIDENT VICTIMS

Background

In the SABS, a first party system, insurers are obligated to treat benefit applications from all of their injured customers with fairness and transparency. In this section we describe several more generic problems with insurer claims handling and provide solutions to make the SABS work more effectively to improve health access and outcomes. These solutions complement the ones described above to address unfair insurer claims handling for accident victims with psychological impairments.

Problems: Current barriers to health access which cause disputes and interfere with outcomes

INSURERS' REVIEW PROCESSES LACK COMMUNICATION AND TRANSPARENCY

Insurers do not give the accident victim or the proposing health professional a reasonable opportunity to respond to any questions when they review an OCF 18. Instead, they deny the benefit. There is a comment section on the application in HCAI that is not utilized by insurers to communicate with the proposing health professional and address any questions. Insurers do not contact the proposing health professional, even if explicitly invited to do so when the application is submitted. Nor do they contact the accident victim for clarification. Often, clarification would have addressed the insurer's questions and allowed timely approval of the application. The lack of communication and the insurer's denial, creates an adversarial atmosphere, adds disputes and costs, as well as delaying and harming the recovery outcomes for the accident victim.

INSURER DENIALS DO NOT INCLUDE "MEDICAL OR OTHER REASONS" AND LACK AN EXPLANATION OF WHY A BENEFIT IS "NOT REASONABLE AND NECESSARY"

Many insurer denials do not include specific "medical or other reasons" and lack a specific explanation of why a benefit is not reasonable and necessary. Health professionals of all disciplines report that insurers frequently fail to provide any medical or other reasons, and only state that the application is not reasonable and necessary. This failure to provide transparency and the reason for the denial causes disputes, delays access, and harms recovery.

The insurer's failure to comply with these SABS requirements and the violation of consumer protection is highlighted in LAT decisions, including, Taksali and Aviva, October 26, 2022. This decision provides a description of what is required for the insurer to fulfill their obligation to provide medical and other reasons for denial of an application. It concludes, *Ultimately, an insurer's "medical and any other reasons" should be clear and sufficient enough to allow an unsophisticated person to make an informed decision to either accept or dispute the decision at issue. Only then will the explanation serve the Schedule's consumer protection goal.*

INSURERS' ADDING CRITERIA TO "REASONABLE AND NECESSARY"

Some insurers add their own criteria to reasonable and necessary, change the requirement to "essential", or demand "compelling evidence" for the proposed services.

Criteria that outline what is included and excluded from reasonable and necessary medical and rehabilitation benefits are already included in the SABS. (See Appendix B). Some have suggested that further defining "reasonable and necessary" would improve insurer claims processing and reduce disputes. However, further defining reasonable and necessary would actually create further complexity, generating disputes regarding the interpretation of any new terms. Any attempt to further define reasonable and necessary is most likely to be misused to deny accident victims' ability to access care they require to restore their function.

Many of the advocates of providing a definition of reasonable and necessary are actually seeking a fundamental shift away from the restorative purposes of the SABS. The current SABS provide funding of "reasonable and necessary" services to reduce impairments and restore function of the individual accident victim. Some of the proposals are for a very limited list of specific services and costs, similar to the model of many employee health benefit packages. For example: up to 10 sessions of psychological treatment to a maximum of $1500; up to 10 sessions of physiotherapy, massage or chiropractic treatment to a maximum of $1000; up to $1000 for dental care. This defined benefit approach would undermine the restorative purposes of the SABS for the individual accident victim.

LACK OF FAIRNESS AND TRANSPARENCY IN "PARTIAL APPROVALS"

Insurers deny or reduce specific items in an assessment or treatment application without providing specific reasons. These are often defacto denials of services but are misleadingly described as "partial approvals".

The "partial approval" often lacks fair consideration of whether the specific proposed services are reasonable and necessary for the individual accident victim. Most often there is no explanation, only that the service is "not reasonable and necessary". Some insurers routinely deny all activities with a specific description and CCI code, stating the activity is not billable". There are also insurance company patterns of denials/reduction of the number of treatment sessions, length of the sessions, and duration of treatment. If an explanation is provided, it usually states, "not what is standard" without providing an actual reference, or "not required for the diagnosis". There is no indication of specific reasons for the denial of the service for the individual accident victim. At best, this gives the appearance of being an arbitrary and dismissive response to the application that appears more bureaucratic than a considered response to the individual injured person's application.

When the accident victim receives "partial approval" for an assessment or treatment plan, they assume that the "partial approval" means they can begin to receive the necessary care that they were seeking, not understanding that the cuts undermine what their treatment provider carefully thought through and is proposing. This is confusing for patients who assume they can rely on their insurer and accident benefits to approve their care. They are misled to believe that the services approved are sufficient to proceed, despite the cuts made by the adjuster which undermine care.

Solutions

FSRA SHOULD IMMEDIATELY INITIATE A MULTI STAKEHOLDER PROCESS TO IMPROVE COMMUNICATION AND UPDATE THE OCF 18

Insurers have commented that they do not have sufficient information to make informed decisions regarding applications for assessments to plan treatment and therefore request additional information or require an IE. To address this proactively, a working group of insurers who review applications and psychologists and other health professionals who submit applications should be convened to report within six months. The tasks for the group should include producing recommendations to improve communication between the proposing psychologist and other health professionals and the insurer to provide a basis for fair decision making. The OCF 18 should be considered by this group in light of its recommendations and updated accordingly.

The OCF 18 needs to be updated to provide relevant information for sound insurer decision making. This process should be completed within six months. The working group should be provided technical support to improve the efficiency of form completion and provide more effective data collection and sharing.

Some areas for improvement of the OCF 18 to be considered include modification to require a statement by the health professional explaining why the proposed services are reasonable and necessary. Similarly, a field should be added to the section for the insurer's response to require them to specify the medical or other reasons for their response, and explain their reason why they determined that any of the specific items proposed on the OCF 18 are not reasonable and necessary for the individual accident victim.

The current OCF 18 severely limits the ability to provide relevant documentation and supportive information. There is currently a restrictive character limit in the "additional comment" section that precludes inserting reports that should accompany the OCF 18. The documents must be submitted outside of the HCAI system which is inefficient for the submitting health professional and for the insurer's review of OCF 18. This character limit should be expanded to make it possible to insert the equivalent of a minimum of 50 pages of documentation. Since these are typically digitized text documents, it is not anticipated that this addition will cause capacity problems. Providing relevant documentation as an integrated part of the OCF 18 will reduce denials that are based on an adjuster lacking information. It should also reduce delays caused by adjusters responding that they need additional information to be sent before they can arrive at a decision. This will also reduce processing costs.

The working group should identify questions on the OCF 18 that are unnecessary, duplicative of information collected on forms previously completed, or require clarification. They should also add fields for further information required for effective communication and decision making.

ENFORCE THE INSURER'S OBLIGATION TO PROVIDE A SPECIFIC MEDICAL OR OTHER REASON TO CLAIM SERVICES ON AN OCF 18 ARE NOT REASONABLE AND NECESSARY

FSRA guidance should enforce insurers' obligations to provide specific and complete medical or other reasons within the ten day timelines of the SABS. FSRA should also confirm the accident victim can proceed with the proposed services until a complete response is provided.

An illustrative case book of insurer denials with no medical or other reasons can be provided for FSRA's risk based follow up.

DO NOT ALLOW INSURERS TO ADD CRITERIA TO "REASONABLE AND NECESSARY"

Disputes often are the result of an insurer's unfair addition or changes to the criteria for approving assessment and treatment plans, such as requiring that proposed services be "essential". This is a systemic issue that requires FSRA guidance and supervision, not individual dispute resolution.

ENFORCE FAIRNESS AND TRANSPARENCY IN "PARTIAL APPROVALS"

Some insurers have systemic patterns of "partial approvals". They routinely deny or reduce certain types of services without any specific explanation. The use of partial approvals may give a false impression of the company's approval rate for benefit applications, since they are not seen as denials. However, many partial approvals are so limited that the health professional is not able to provide any service.

Evaluation of the specific patterns of partial approvals by insurance company is required for risk based follow-up by FSRA. The OPA and other health professionals can also provide a case book of examples of "partial approvals" where no reason was provided by the insurer.

FSRA SHOULD DIRECT HCAI TO PRODUCE MORE ROBUST REPORTS, BETTER UTILIZING THE WEALTH OF AVAILABLE INFORMATION.

More comprehensive and accessible reports are needed to provide relevant data including patterns of insurer denials. Extensive information is currently entered into HCAI regarding every application and every insurer response. More specific data reports regarding patterns of insurer denials is required to identify questionable insurer and/or provider practices for further analysis. Reports regarding denials and partial approvals should include: percentage by insurance company; percent by injury type; treatment type; and by provider type. Each of these reports by type should also be analyzed by insurance company. This information can provide a basis for understanding and addressing specific patterns and remedies for the high number of denials and resulting disputes.

FSRA SHOULD PROVIDE GUIDANCE TO ADDRESS REPEATED SYSTEMIC ISSUES.

The systemic issues and insurance company policies which are not specific to an individual accident victim's individual impairment or treatment plan are more appropriately addressed at a system level than by requiring individual dispute. An example of a generic issue is, "HST is to be paid in addition to

the Professional Services Guideline (PSG) fee". Actually this and other common systemic issues should be identified for FSRA guidance to avoid individual disputes.

CHOICE

Background

Insurers' have proposed "choice" or "optional" coverages at the time of the purchase to allow individual consumers to reduce their insurance costs. This model is seen in many of the advertisements for American auto insurance, in ads that state, "buy the coverage you need".

When considering proposals for adding any "options," the different contexts between the United States and Ontario must be considered. Auto insurance in the United States is embedded in an overall system which relies much more heavily on private insurance rather than public health and social services. Americans therefore may be more aware and able to evaluate the risks and consequences of decisions regarding their private insurance coverage that save money in the short term. Ontario accident victims may falsely assume that publicly funded healthcare and welfare systems will be enough to cover their injuries and impairments as a result of an accident, and thus opt out of coverage they do not understand they may need. In addition, since auto insurance is a required by government, consumers may incorrectly assume that it has been determined that the minimum required benefits are sufficient.

For most consumers it is impossible to get relevant practical information to make an informed decision regarding the cost savings compared to the increased risk of loss inherent in any option. As an example, the option to forego coverage for auto body damage is a far more predictable risk of costs and loss than many others. However, even for this option most consumers would not be able to understand the terms and appreciate the financial risks of their decision even if they received the standard information sheet provided by an insurer or broker.

Any additional options at this time would add complexity and confusion, as well as create disputes, with no assurance of a significant positive impact on costs and premiums.

The most harmful and problematic of the options which were proposed would be to allow an option to be restricted to the insurer's PPN for health care in exchange for premium reduction. It would be exceptionally harmful to the recovery of accident victims with psychological impairments and this option should not be allowed. This is discussed above.

Problems

INCREASED OPTIONALITY WOULD NOT SAVE COSTS. IT WOULD UNFAIRLY TRANSFER COSTS TO THE MOST VULNERABLE~~,~~ WHO CAN LEAST AFFORD IT.

Pooled risk requires that the pool of insureds includes both those with high and low risk of use of the benefit. If those with lowest risk of needing a benefit opt out of the benefit, for example income replacement, then those who are most vulnerable, (both most likely to need the benefit and least likely to be able to afford it) are faced with increased costs for the benefit.

IF THE COVERAGE IS NOT PURCHASED, THE COSTS ARE TRANSFERRED TO PUBLIC HEALTH AND WELFARE.

One of the purposes of auto insurance is to avoid transfer of the costs of auto accidents to public health and welfare systems. If consumers do not have sufficient auto insurance coverage to provide necessary care and other benefits such as income replacement, these needs and costs do not disappear. The overall burden is transferred to public funding sources.

CONSUMERS' ABILITY TO MAKE WELL INFORMED DECISIONS REGARDING THE CURRENT CHOICES MUST BE IMPROVED.

FSRA's consumer response panel documented how challenging it is for consumers to get information to make purchasing decisions. Direct experience and patient reports confirm this difficulty obtaining information. For example, almost no one is informed about insurer ownership of the broker firm or the commission structure. Recent investigations regarding the failure to follow the "take all comers" rule has also revealed the failure to ensure accuracy of information provided by on-line services.

Similarly, the benefit of optional catastrophic impairment level coverage and the cost, (providing significant additional benefits at minimal costs}, is rarely mentioned. The current structure, needing to "buy up," is a disincentive to both the broker or direct seller and the customer.

Solutions

DO NOT ALLOW AN OPTION TO OFFER A REDUCED PREMIUM IN EXCHANGE FOR AN AGREEMENT TO BE RESTRICTED TO THE INSURER'S PPN FOR HEALTH CARE.

Maintain the current system which allows insurers to offer use to their PPN at time of injury and protect the injured person's right to choose alternative providers who are not in the insurer's PPN with no negative consequences.

FSRA MUST ENFORCE SELLERS' OBLIGATIONS FOR DISCLOSURE TO CUSTOMERS.

The FSRA Automobile Insurance Supervision Plan 2023-2025 for supervision of auto insurers states,

> *Disclosure to Customers – Before concluding a contract, customers should be appropriately informed of the premium amounts, policy benefits, duration, limitations, exclusions and their rights and obligations. This information enables the customer to make an informed decision before entering a contract... FSRA Market Conduct is interested in the process used by insurers to ensure the information provided to customers is clear and timely, regardless of the distribution channel. This attention is aimed at preventing and/or identifying potential unfair or deceptive practices that may mislead customers in the absence of and transparent information. Supervision of this activity will improve customer understanding, creating an environment where customers can make well-informed decisions about their insurance needs.*

As described above, personal experience and patient reports indicate that sellers fail to meet this standard. It would be helpful if FSRA would require all sellers to document that they have provided each customer with all of the information listed in an easily understood format, and informed the customer of the process to complain if they have not been satisfied with the process. FSRA could impose penalties and make public any pattern identified of non compliance with these expectations.

THE AUTO INSURANCE PRODUCT MUST NOT BE MADE MORE COMPLEX

We are aware that there are many challenges in providing required information for informed decision making given multiple private companies, policy details, distribution channels, even when the seller is making a sincere effort. It is further complicated by differences in consumer literacy and knowledge of auto insurance and contract law.

Therefore, it is essential that the standard insurance policy not be reduced or made more complex. Any options introduced should be to enhance the current policy amounts.

COST CONTROL

Background

The cost of auto insurance premiums is an ongoing focus of attention. Given the relatively small and decreasing percentage of costs of med/rehab benefits, even removing these benefits entirely would not create significant savings. The large and growing costs due to organized crime, auto theft and auto body repair must be controlled.

Problem

Many proposed regulation changes to reduce accident benefits would harm those who are injured, by further reducing and restricting access to care. This conflicts with the goal of improving health access and outcomes. Reducing benefits and restricting access would also transfer costs to public health and welfare systems.

Solutions

Cost Control requires controlling the high and rapidly increasing costs of organized crime, auto theft, auto body damage including: towing, storage, rental, and repair.

Many of the cost controls that have been put in place for health providers are absent from the auto body damage sector including: FSRA fee schedules; FSRA licensing; use of HCAI for direct payment, etc. This announced provincial licensing of towing facilities seems to be a step toward the necessary control.

CRACK DOWN ON ORGANIZED CRIME, AUTO THEFT, AND FRAUD

Background

Cost control requires addressing organized crime, auto theft and fraud.

There is no indication that individual consumer or health professional fraud is a significant cost. Any instances of health provider and individual consumer fraud can be addressed through more effective use of current tools including: Improvement of the OCF forms; HCAI data mining and more open data access; FSRA licensing, including penalties and suspension; Regulatory colleges, including penalties and suspension, etc.

Regarding any concerns of potential misuse of claims of psychological impairments, insurers have data analytic capacity that allows them to identify patterns and individual instances requiring further scrutiny. We recommend that the many mechanisms that are currently available to target specific instances of suspected abuse be utilized rather than treating all applications as potential instances of fraud or exaggeration.

These anti-fraud tools can be used to identify individual instances for further scrutiny and to respond to instances of abuse, whether by claimants, health professionals, insurers, or others. FSRA health service provider licensing and regulatory college processes can be utilized to provide effective sanctions in individual instances of unfair or deceptive practices, or fraud.

Problem

The current explosion of organized crime and auto theft is documented in insurance publications and the general media. This creates both a public hazard, for example in staged accidents and car jacking, and untenable costs.

Solutions

We fully support the government’s initiatives which have led to more effective utilization of data to identify fraud and crime and utilization of multi-jurisdictional anti-crime initiatives. Recent media coverage shows the extent and cost of car theft and beginnings of success at identification and recovery. This enforcement may may also deter other bad actors.

APPENDIX

Appendix A: SABS re Insurers' Preferred Provider Networks

Section 46 Conflict of interest re referrals by insurer

(1) This section applies if an insurer intends to refer an insured person to a person with whom the insurer has a potential conflict of interest and the referral is for the purpose of,

the insured person obtaining any goods or services referred to in section 15 or 16 from the person recommended by the insurer; or

the insured person being examined or assessed, other than under section 44, by the person recommended by the insurer. O. Reg. 34/10, s. 46 (1).

The insurer shall not refer the insured person to the person unless the insurer has first given the insured person a notice that satisfies the following and the insured person gives a written consent to obtain the goods or services from or be examined or assessed by the person:

The notice must specify the nature of the relationship between the insurer and the person, including the terms of remuneration of the person.

The notice must specify the nature, amount and duration, if applicable, of the goods or services or the assessment or examination.

The notice must inform the insured person that he or she is free to decline the proposed referral, or to revoke any consent given at any time, and that doing so will not prejudice or adversely affect the insured person's entitlement to benefits.

The notice must inform the insured person that he or she is free to choose from whom the insured person prefers to receive the goods and services, or by whom the insured person prefers to be assessed or examined, in accordance with this Regulation, and that doing so will not prejudice or adversely affect the insured person's entitlement to benefits under this Regulation.

The notice must inform the insured person of his or her rights and responsibilities with respect to the goods, services, assessments and examinations. O. Reg. 34/10, s. 46 (2).

In this section, an insurer is deemed to have a potential conflict of interest with a person if,

the insurer may receive a financial benefit, directly or indirectly, as a result of the provision of goods or services by, on behalf of, or under the authority or supervision of the person; or

goods or services will be provided by, on behalf of, or under the authority or supervision of the person,

pursuant to a subsisting arrangement with the insurer under which goods or services referred to in this Regulation are or will be provided at the insurer's expense, or

as a result of the insurer's referral, recommendation or suggestion of the person to the insured person. O. Reg. 34/10, s. 46 (3).

Appendix B: SABS re reasonable and necessary medical and rehabilitation benefits

PART III

MEDICAL, REHABILITATION AND ATTENDANT CARE BENEFITS

Insurer liable to pay benefits

4. Except as otherwise provided in this Regulation, an insurer is liable to pay the following benefits to or on behalf of an insured person who sustains an impairment as a result of an accident:

1. Medical and rehabilitation benefits under sections 15 to 17.

2. If the impairment is not a minor injury, attendant care benefits under section 19. O. Reg. 34/10, s. 14.

Medical benefits

5. (1) Subject to section 18, medical benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for,

(a) medical, surgical, dental, optometric, hospital, nursing, ambulance, audiometric and speech-language pathology services;

(b) chiropractic, psychological, occupational therapy and physiotherapy services;

(c) medication;

(d) prescription eyewear;

(e) dentures and other dental devices;

(f) hearing aids, wheelchairs or other mobility devices, prostheses, orthotics and other assistive devices;

(g) transportation for the insured person to and from treatment sessions, including transportation for an aide or attendant; and

(h) other goods and services of a medical nature that the insurer agrees are essential for the treatment of the insured person, and for which a benefit is not otherwise provided in this Regulation. O. Reg. 34/10, s. 15 (1); O. Reg. 251/15, s. 5.

(2) Despite subsection (1), the insurer is not liable to pay medical benefits,

(a) for goods or services that are experimental in nature;

(b) for expenses related to goods and services described in subsection (1) rendered to an insured person that exceed the maximum rate or amount of expenses established under the Guidelines, other than for expenses related to the services described in clause (1) (g); or

(c) for transportation expenses other than authorized transportation expenses. O. Reg. 34/10, s. 15 (2); O. Reg. 14/13, s. 1.

Rehabilitation benefits

6. (1) Subject to section 18, rehabilitation benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person in undertaking activities and measures described in subsection (3) that are reasonable and necessary for the purpose of reducing or eliminating the effects of any disability resulting from the impairment or to facilitate the person's reintegration into his or her family, the rest of society and the labour market. O. Reg. 34/10, s. 16 (1).

(2) Measures to reintegrate an insured person into the labour market are considered reasonable and necessary, taking into consideration the person's personal and vocational characteristics, if they enable the person to,

(a) engage in employment or self-employment that is as similar as possible to the employment or self-employment in which he or she was engaged at the time of the accident; or

(b) lead as normal a work life as possible. O. Reg. 34/10, s. 16 (2).

(3) The activities and measures referred to in subsection (1) are,

(a) life skills training;

(b) family counselling;

(c) social rehabilitation counselling;

(d) financial counselling;

(e) employment counselling;

(f) vocational assessments;

(g) vocational or academic training;

(h) workplace modifications and workplace devices, including communications aids, to accommodate the needs of the insured person;

(i) home modifications and home devices, including communications aids, to accommodate the needs of the insured person, or the purchase of a new home if it is more reasonable to purchase a new home to accommodate the needs of the insured person than to renovate his or her existing home;

(j) vehicle modifications to accommodate the needs of the insured person, or the purchase of a new vehicle if it is more reasonable to purchase a new vehicle to accommodate the needs of the insured person than to modify an existing vehicle;

(k) transportation for the insured person to and from counselling and training sessions, including transportation for an aide or attendant; and

(l) other goods and services that the insurer agrees are essential for the rehabilitation of the insured person, and for which a benefit is not otherwise provided in this Regulation, except,

(i) services provided by a case manager; and

(ii) housekeeping and caregiver services. O. Reg. 34/10, s. 16 (3); O. Reg. 251/15, s. 6.

(4) Despite subsection (1), the insurer is not liable to pay rehabilitation benefits,

(a) for expenses related to goods and services described in subsection (3) rendered to an insured person that exceed the maximum rate or amount of expenses established under the Guidelines, other than for expenses related to the services described in clause (3) (k);

(b) for expenses incurred to renovate the insured person's home if the renovations are only for the purpose of giving the insured person access to areas of the home that are not needed for ordinary living;

(c) for the purchase of a new home in excess of the value of the renovations to the insured person's existing home that would be required to accommodate the needs of the insured person;

(d) for expenses incurred to purchase or modify a vehicle to accommodate the needs of the insured person that are incurred within five years after the last expenses incurred for that purpose in respect of the same accident;

(e) for the purchase of a new vehicle in excess of the amount by which the cost of the new vehicle exceeds the trade-in value of the existing vehicle;

(f) for transportation expenses other than authorized transportation expenses. O. Reg. 34/10, s. 16 (4); O. Reg. 14/13, s. 2.