Appendix A:

An Overview of the Attendant Care Benefit

Ontario's no-fault automobile insurance system was put into effect with the Ontario Motorist Protection Plan (OMPP) which commenced on June 22, 1990. Under OMPP, Ontarians would be eligible for various benefits from their own insurer if they were injured in a motor vehicle accident. One of the benefits that could be received (in addition to medical and rehabilitation benefits and income replacement benefits) was a "care benefit". Under OMPP, care benefits were paid by the insurer for care required by the claimant based on either the "reasonable cost of a professional care-giver" or "the amount of gross income reasonably lost by a person other than the insured person as a result of the accident in caring for the insured person." Additionally, care benefits included "all reasonable expenses resulting from the accident in caring for the insured person after the accident." The maximum amount payable for care services was $3,000 per month with an overall maximum care benefit payable of $500,000 over an insured's lifetime (*Ref. O. Reg. 672/90, O. Reg. 660/93 and O. Reg 779/93 Part II, Section 7 (1)(2)(3))*.

On January 1, 1994, Bill 164 came into effect with sweeping changes to the no-fault accident benefit system. Where "attendant care" benefits were specifically concerned, insurers became required to pay for "*all reasonable expenses incurred by or on behalf of the insured person for the services provided by an aid or an attendant or services provided by a long-term care facility, including a nursing home, a home for the aged or chronic care hospital*." Family members were permitted to provide care services and be paid the attendant care benefit. The aide or attendant was not required to possess any special qualifications. The *Form 1 Assessment of Attendant Care Needs* was also first introduced as the tool to be used to calculate the quantum of money that a person could receive through the attendant care benefit.

The maximum monthly benefit payable was $<u>3,000</u>; however, if a person suffered a spinal cord injury, severe brain injury, an upper bilateral amputation or other injuries that cause the total loss of use of both hands or arms, the maximum monthly benefit payable was $<u>6,000</u> per month. A maximum of $<u>10,000</u> per month was available to an insured person if they suffered a severe brain injury which caused violent behaviour that could result in physical harm to themselves or others. A maximum of $<u>10,000</u> per month was also available to individuals who were eligible for $6,000 per month of care (i.e. persons with severe brain injuries, spinal cord injuries and upper bilateral amputations/loss of use of both hands or arms) AND they additionally suffered another injury that, by itself, would have required attendant care services. These benefits could continue over the claimant's lifetime with no maximum limit. Annual indexation was applied to medical rehabilitation limits*, <u>as well as the monthly attendant care hourly rates AND the respective monthly attendant care benefit maximums</u>.*

When Bill 59 came into effect on November 1, 1996, a "tiered" benefits system was put into place. The maximum monthly attendant care benefit payable was $3,000 per month for a maximum of 10 years for a person whose impairments are considered to be eligible for the "non-catastrophic" tier of benefits. And $6000 per month was available for a person who suffered impairments that qualified for the "catastrophic" tier over the claimant's lifetime. However, both "tiers" are also subject to the maximum available under the medical, rehabilitation and attendant care limits.

> *(Note: Individuals who purchased specific optional benefits may also have up to $6000 per month in attendant care benefits regardless of their impairment category. The monthly maximum attendant care limits were no longer indexed in keeping with the CPI unless the insured person purchased the optional indexation benefit as part of their automobile insurance policy.)*

In addition to the changes that took effect on November 1, 1996, other changes concerning the attendant care benefit were also put into place over time. These include:

a) which professionals can complete attendant care assessments/Form 1's (i.e. Since September 1, 2010, only nurses and occupational therapists are permitted to complete these assessments.)

b) the maximum amount payable to a health care professional to complete an attendant care assessment,

c) who can be paid the attendant care benefit (i.e. Since June 1, 2016, family members are only able to receive the attendant care benefit if they provide the care and experience an economic loss in doing so; otherwise, attendant care services must be provided by a professional caregiver), and,

d) the maximums payable in attendant care benefits, as outlined in the chart below, which have eroded over time.

Erosion of the Attendant Care Benefit

Since November 1, 1996, when the "tiered system" of benefits was introduced in the SABS, the total costs of medical, rehabilitation, and attendant care benefits that are payable to an insured person have substantially eroded, thus impacting the duration with which benefits can be available to assist Ontarians who are seriously injured from motor vehicle accidents. These changes are reflected in the following chart:

Benefit	Accidents occurring between January 1,1994 and October 31, 1996	Tier	Accidents occurring between November 1, 1996, and August 31, 2010	Accidents occurring between September 1, 2010, and May 31, 2016	Tier	Accidents occurring after June 1, 2016, and to the present day
Medical and Rehabilitation Benefits	$1 million over lifetime	Minor Injury	n/a	$3500	Minor Injury	$3500
		Non-Cat Med/ Rehab	$100,000 for max of 10 years	$50,000 for max of 5 years	Non-Cat Med/ Rehab AND Attendant Care	Combined total of $65,000 for both benefits for max of 5 years
		Cat	$1 million over lifetime	$1 million over lifetime		
Attendant Care Benefits	$1 million over lifetime	Minor Injury	n/a	n/a	Minor Injury	n/a
		Non-Cat Med/ Rehab	$72,000 for max of 2 years	$36,000 for max of 2 years	Cat Med/ Rehab AND Attendant Care	Combined total of $1 million for both benefits over lifetime
		Cat	$1 million over lifetime	$1 million over lifetime		

To highlight the current situation in real terms using today's benefit limits, if a catastrophically impaired person with tetraplegia were to *only* use their attendant care benefit of $6,000 per month (and did not incur any medical or rehabilitation expenses), their current $1 million for combined med/rehab and attendant care benefits would last a maximum of 13.8 years. The fact that individuals not only require necessary (and often vital) attendant care services, but also medical and rehabilitative goods and services means that the attendant care benefit limits remain woefully insufficient to meet their needs - regardless of their catastrophic or non-catastrophic status. It also means that the publicly funded health and social care system (which is presently under significant strain), will continue to be relied upon to fill the resulting limitations in the accident-benefits system. The fact that claimants face increasing difficulty having their care needs met through the attendant

care benefit means that there will be increasingly higher direct and indirect social and economic costs which should not be overlooked from a policy development perspective.

(Note that individuals who are eligible for attendant care benefits through their accident benefits insurer are *not* eligible for publicly funded home care services provided through the Ministry of Health because, for these specific benefits, auto insurers are considered the priority payor *ref. Corporate Services Division Supply Chain and Facilities Branch Subrogation Unit document, catalogue Number 014389, dated April 2010*).

Problems with Calculating the Attendant Care Benefit and Accessing Care

Since November 1, 1996, and to the present day, it has continued to be the statutory requirement that the calculation of the attendant care benefit be based on the *Form 1 Assessment of Attendant Care Needs*.

The Hourly Rates on the Form 1 Do NOT Represent the Actual Cost to Purchase Care

Since the adoption of the Form 1 as a tool for calculating the attendant care benefit, there has always been a "mismatch" between what the Form 1 will state in terms of the number of hours of care a person requires and the actual number of hours that can be purchased with the calculated benefit. This is because the rates that are used for calculating the benefit have been perpetually, and substantially, lower than the actual hourly rates that are charged by community care agencies. Resultantly, it is understood that the attendant care benefit, by design, has only ever been intended to partially pay for the care that claimants require to help them after they are injured in a motor vehicle accident.

In fact, on the FSRA webpage entitled "*After an Accident: Understanding the Claims Process*" under the drop-down menu entitled "*What to Expect After You Have Been Injured*", it is noted that "A*ttendant Care: Pays some* [emphasis added] *of the costs of an aide or an attendant.*" (ref. *https://www.fsrao.ca/consumers/auto-insurance/protect-yourself/after-accident-understanding-claims-process*).

Moreover, in a 2021 Superior Court of Justice Decision (Malitskiy v. Unica Insurance Inc., 2021 ONSC 4603), which addressed a dispute concerning entitlement to the attendant care benefit, Justice J.J. Lederer writes,

> *"The Statutory Accident Benefits Schedule reflects the continuing effort of the legislature to impose a partial no-fault regime to allow for some compensation to be paid at the outset. Over time there have been several iterations aimed at finding a balance that provides some speedy payment but, in company with, insurance rates that are not unreasonably high. The Statutory Accident Benefits Schedule is the current scheme in place to accomplish these goals. The legislature has not adopted a full no-fault scheme. Where injuries are catastrophic, it is not expected that full compensation of any particular expenses would necessarily be received through this preliminary regime."*

As noted earlier, the *Form 1 Assessment of Attendant Care Needs* first began being used as a tool to quantify a claimant's attendant care benefit eligibility and payment on January 1, 1994. At that time, the hourly rates used to calculate the benefit were prescribed under subsection 50(10) of the Statutory Accident Benefits Schedule (SABS) and were as follows:

- $8.75 per hour for care described in Part 1 of the Form 1 (i.e. routine personal care),
- the minimum hourly wage for care described in Part 2 of the Form 1 (i.e. basic supervisory care), and,
- $14 per hour for care described in Part 3 of the Form 1 (i.e. complex health/care and hygiene functions).

The following chart presents the historical evolution of the hourly rates used to calculate the attendant care benefit using the Form 1. Here, the reader can see that the historical hourly rates that have been used to calculate the benefit have been limited and have not appreciably risen since 1996. They have never reflected

the actual, reasonable and customary cost of services provided by established and reputable community care agencies (many of which are retained to provide care through the province's publicly-funded home care system as well).

Superintendent's Attendant Care Guideline Applicability	Superintendent's Guideline #	Level 1 Hourly Rate	Level 2 Hourly Rate	Level 3 Hourly Rate
Accidents occurring on/after November 1, 1996	n/a - use Form 1 as read on Sept 30, 2003 (O.Reg. 281/03 s. 35)	$9.00	$7.00	$15.00
Accidents occurring between October 1, 2003, and February 28, 2006 (O.Reg.403/96)	n/a - use Form 1 as it read on September 30, 2003 (i.e. Form 1 dated June 2003)	$10.53	$7.00	$16.86
Accidents occurring between March 1, 2006, and January 31, 2007 O.Reg. 403/96, S.39 (16)	n/a - use Form 1 dated December 31, 2005	$11.23	$7.75	$17.98
Accidents occurring on/after February 1, 2007, and before March 30, 2008	n/a use Form 1 dated December 31, 2006	$11.23	$8.00	$17.98
Accidents occurring between March 31, 2008, to August 31, 2010	n/a	$11.23	$8.75	$17.98
September 1, 2010, to May 31, 2014	No. 03/10 Form 1 effective date Sept 1, 2010	$13.19	$10.25	$19.35
June 1, 2014, to September 30, 2015	No. 02/14	$13.19	$11.00	$19.35
October 1, 2015, to September 30, 2016	No. 02/15	$13.19	$11.25	$11.40
October 1, 2016, to September 30, 2017	No. 03/16	$14.90	$11.40	$21.11
October 1, 2017, to December 31, 2017	No. 02/17	$14.90	$11.40	$21.11
January 1, 2018, to April 13, 2018	No. 03/17	$14.90	$14.00	$21.11
Accidents occurring after April 14, 2018	No. 01/18	$14.90	$14.00	$21.11

To exemplify the "mismatch" situation in today's terms, the reader must first understand that, presently, most care agencies in Ontario charge between $35 and $45 per hour (plus applicable taxes) for care services provided by a Personal Support Worker (PSW). As can be seen in the chart, above, the current hourly rates that are currently assigned to be used in calculating the attendant care benefit are only $14.90, $14.00, and $21.11. This means that if a person requires "only" supervisory care (which is paid at the level 2 rate of $14.00 per hour), they will never be able to afford the *actual* number of hours they are assessed to need as documented on the Form 1 using the attendant care benefit alone. This also remains the case even when a person is assessed as needing help under other categories of care.

Simply put, the rates that are used to calculate the benefit do not reflect the actual market rate to purchase care services in Ontario. ***Resultantly, injured claimants who require attendant care services will never be able to have all of their care needs met through attendant care benefit funding alone***.

Purchasing of Sufficient Care Hours is Restricted Due to the Monthly Benefit Caps

The maximum monthly attendant care benefit caps of $3,000 and $6,000 (for persons who sustain non-catastrophic and catastrophic impairments, respectively) reduce the "purchasing power" of the attendant care benefit. For example, if a catastrophically impaired person who experiences tetraplegia is assessed as requiring 24/hours of care per day and pays $40/hour for care services for agency-based care, they can only purchase an overall average of 4.93 hours of care per day because of the $6,000/month cap. Therefore, raising the attendant care hourly rates on the Form 1 without raising the monthly maximum cap will only be helpful to claimants whose calculated benefit is less than $3,000 or $6,000 per month. Nevertheless, doing

so will increase the purchasing power of the attendant care benefit for eligible claimants whose calculated benefit does not meet the monthly caps.

In 1996, for catastrophically injured people requiring 24-hour care, the maximum benefit of $6,000 per month could be used to purchase approximately 8 hours of care per day at the usual and customary agency hourly rates. However, the cost of living has risen over time and with it wages for PSW services and the reasonable and customary hourly rates charged by care agencies. Resultantly, the number of hours that could be purchased in 1996 can no longer be purchased, now 28 years later, in 2024. In 2024 terms, $6000 per month now only affords claimants approximately 4.5 hours of care per day. This is insufficient to allow claimants with serious injuries (who, for example, require 24-hour care due to severe brain injuries or spinal cord injuries) to receive the level of care they require. In these cases, it does not allow family caregivers the opportunity to maintain employment, which can translate to challenges with housing/food security, caregiver burnout, and higher potential for publicly funded residential care becoming necessary, etc.

The Compounding Impact of the Unica v. Malitskiy Decision

As noted in the examples, above, although the *calculation* of the attendant care benefit has been based upon the Form 1, *in practice*, claimants have been historically permitted to purchase as many hours as can be afforded each month by using the full monthly benefit entitlement and dividing this by the hourly rate charged by the professional caregiving agency who is retained to help them and then scheduling these hours in keeping with their needs and preferences. HOWEVER, there have been at least two decisions which have challenged this way of using the attendant care benefit over the years; one being an August 8, 2017, LAT decision (1*6-001063, A.H. and Belair Insurance Company)* and more recently a June 29, 2021, Divisional Court decision (*Malitskiy v. Unica Insurance Inc., 2021 ONSC 4603*). In these situations, the LAT adjudicator (Ms. Lori Marzinotto) and the Justice, J. Lederer, respectively, determined that *payment* of the attendant care benefit could be restricted to using the hourly rates listed on the Form 1 (as outlined in the ACHRG) which were originally only intended for the *calculation* of monthly benefit quantum.

After above-noted 2017 LAT decision, some insurers began imposing hourly rates for services provided by care agencies/professional care staff and exclusively using the rates listed on the Form 1. This created significant confusion for vendors who struggled to ascertain which level of service was being provided to the claimant at which hourly rate. Importantly, however, this method of payment created a significant shortfall between the hourly rate paid by the insurer and the average market rates charged by professional care agencies/providers. Due to affordability issues, many people were left without support, despite their clear need for care services.

In response to insurers' behaviour, FSRA issued a revised Attendant Care Guideline on April 11, 2018 (r*ef. Superintendent's Guideline No. 01/18*). This guideline clarified that the hourly rates listed on the Form 1 were to be used to calculate the benefit and that they were not intended to be used to pay for attendant care services. However, since the 2021 court decision (Malitskiy vs. Unica), some insurers (e.g. predominantly Economical Insurance and their subsidiaries, and other insurers on an occasional basis) have required that attendant care providers/agencies to itemize the specific type and duration of each task they perform during the course of providing care to the injured person <u>and have, again, been paying agencies based on the duration of each task performed in each category of care prescribed on the Form 1, and are again only paying for care using the hourly rates prescribed on the Form 1 for each category</u>.

As occurred in 2017, when the attendant care benefit is paid using the rates on the Form 1, the insured person became responsible for paying the difference between the Form 1 hourly rates (i.e. $14.90, $14.00, and $21.11) and the market hourly rate of the attendant care agency (i.e. $35-$45 per hour) to the attendant care company and further eroded the claimants access to the care that they require. For example, if the majority of hours that a claimant requires is scored under "Level 2" care on the Form 1 (which is calculated using $14.00/hour), the difference in the hourly rate paid by the insurer and that which the claimant must pay to

receive the care they need, can be as high as $20-$30 per hour. In this situation, if a person uses 5 hours per day of attendant care (e.g. to help with their morning and evening routines), then the cost to the client can be upwards of $150 per day, which translates to $4,562.50 per month or $54,750 per year.

Most clients cannot afford the burden of this extra cost after being injured in a motor vehicle accident; particularly, when they are receiving a mere maximum income replacement benefit of only $400/week. Therefore, when insurers use the Form 1 hourly rates to pay for attendant care services, most claimants who may desperately need attendant care support will never be able to receive it from their insurer. This creates further strain on the publicly funded home care system (who would be forced to step in in many cases, despite the priority payor rules), and the costs for care will be born from taxpayers' dollars instead of being paid by the insurance companies who have a regulatory duty and obligation to their insureds to deliver the benefits outlined on their policy in good faith.