

REPORT TO MINISTER FROM THE ADVISORY PANEL ON CATASTROPHIC IMPAIRMENT

The following is the report and recommendations of the Advisory Panel that was commissioned to re-assess the definition of catastrophic impairment. The following recommendations reflect the mandate of this Panel, which was to “review the definition of catastrophic impairment” contained in the *Automobile Insurance Rate Stability Act* 1996 so that any requisite fine-tuning can be considered”.

We were also asked to make particular reference to amendments that may improve the manner in which this definition impacts upon children.

The format of this report will be as follows:

Each recommendation or alternate recommendation will be identified under a separate heading. There will follow a brief discussion with respect to the deliberations of the Panel and the ultimate conclusion as reflected in the recommendation.

Once the Minister has had an opportunity to review the proposals, the Panel as a whole or any member of the Panel, would be pleased to meet with Mr. Young or any other representative of the Government to answer any questions or elaborate on any of the recommendations. We would also be pleased to respond to any questions or submissions that may be made by stakeholders. The Panel wished to also report to the Minister that while fairness to all policyholders has been one of the criteria that we have looked at with respect to correcting the gaps and inequities in the current definition for the purposes of our recommendations, that equally as important is fairness to all policyholders from a costing perspective. At the time of completing this report, actuarial costing have not been finalized. The Panel recognizes that this Government looks to “rate stability” as well as fairness but because of the limited time given to the Panel to complete our report, we have not been able to address the issue of costing. While we understand that the actuary will continue to do the costing and thus allow the Government to review the issue of rate stability, the Panel must point out that they never had an opportunity to address that issue.

The Panel recognizes that the mandate was to try to create a balance between fine-tuning the definition of catastrophic impairment to adjust any inequities or unfairness in that definition, as well as maintaining rate stability. Inasmuch as rate stability is a prime issue for the Government, the Panel is concerned that its recommendations have not, as yet, been put to that test through costing.

Finally, the Panel would have preferred to have had the option of not simply fine tuning the definition of catastrophic impairment but redrafting it in its entirety. It is the Panel's view that generally this definition may be unworkable and, in many respects, unfair. Further, even with respect to the Mandate that this Panel was given, it was felt that there was insufficient time to truly address the subject in the depth and breadth that most Panel members would have liked.

MEMBERS OF THE ADVISORY PANEL

Attached as Schedule "A" to our report is a list of the members of the Panel and their respective areas of practice. We feel sure that you will note that this Panel was made up of individuals with considerable expertise in their particular area of practice. Each member of the Panel has put in a substantial amount of volunteer work to review medical literature, seek information, attend meetings, participate in discussion groups and review draft legislation to assist in our deliberations and conclusions. As Chair of the Panel, I extend my thanks to each and every member who worked well and beyond the call of duty.

RECOMMENDATION NO. 1

The Panel recommends that the following provisions of the definition remain unchanged:

- a) paraplegia or quadriplegia
- d) total loss of vision in both eyes

It is felt that these sections are clear and that the impairment described represents a catastrophic injury that justifies possible access to increased limits for the various accident benefits. This recommendation met with the consensus of the Panel.

RECOMMENDATION NO. 2

The Panel recommends that the present paragraphs (b) and (c) which presently read as follows:

- "b) amputation or other impairment causing the total and permanent loss of use of both arms,

- c) amputation of other impairment causing the total and permanent loss of both an arm and a leg”

be changed to read as follows:

- “b) **amputation or impairment causing the total and permanent loss of use of the following:**
 - i) **both arms;**
 - ii) **both legs, or;**
 - iii) **both an arm and a leg.”**

The primary change to this is to include in the definition, the permanent loss of use or the amputation of both legs. Under the *AMA Guides*, the loss of both legs represents a 54% whole body impairment. However, it is a consensus of the Panel that the loss of both legs either by amputation or the permanent loss of use is so catastrophic in nature irrespective of the accommodation that may be made through appropriate prostheses that the change should be made so that access could be had to the higher limits. This is particularly so in the case of attendant care where an individual with the permanent loss of use of both legs certainly initially and possibly on a long term basis may require attendant care in excess of \$3,000.00 per month. Similarly, when looking at medical and rehabilitation benefits, if an individual loses both legs and these are replaced by prostheses, the replacement cost of those prostheses in the first ten years alone would be well in excess of \$100,000.00. When one looks at what the general public would consider “catastrophic impairment” it was the belief of the Panel that one would generally expect that an individual who had lost both legs would be considered catastrophically impairment in laymen’s terms.

Rather than leave the question of whether some other impairment in combination with the loss of both legs, allowed an individual to qualify under the 55% whole body impairment category, it is the belief of this Panel that early access to full attendant care and full medical and rehabilitation without concern for the \$100,000.00 limit is imperative for such individuals.

The Panel also wishes to advise the Minister that it spent a considerable amount of time discussing whether the loss of one leg, whether it would be above the knee, below the knee or a whole leg amputation, should qualify as catastrophic impairment. The Panel recognizes that the loss of a leg in either of those circumstances would not qualify under the 55% whole body impairment rule looking at the leg loss only. However, the Panel was seriously concerned that the Legislation did not address the fact that a young man or young woman who had lost a leg in an accident, would not have sufficient medical and rehabilitation

benefits to cover replacement prostheses for their lifetime. The limit of \$100,000.00 would simply not suffice to provide a lifetime of replacement prostheses particularly as the prostheses are becoming more complex and expensive. While the Panel recognizes that the Assistive Devices Program does defray the cost to some degree and is first loss over the Accident Benefit policy, it was suggested that even with full access to the ADP Program, the \$100,000.00 limits would not cover a lifetime of prosthetic expenses. Also raised was the fact the ADP Program was only a plan and is not statutorily legislated and therefore can be withdrawn at any time.

Panel members Stephen E. Firestone, Dr. Harold Becker, Dr. Peter Rumney, Dr. Bob Gates and Dr. Faith Kaplan recommended that the definition of catastrophic be amended to include the loss of a leg and/or the loss of an arm. The Committee members who did not endorse this recommendation were Mr. Steven Whitelaw, Ms. Carol Jardine and Miss Philippa Samworth.

In the alternative, it was the consensus of the Panel that the Government should consider creating an additional benefit for a one-arm amputee and/or one-leg amputee which would allow them to access monies to cover prosthetic devices for a lifetime over and above the non-catastrophically impaired limits of \$100,000.00. In other words, an individual who lost a leg only, while not being catastrophically impaired, would have access to some additional monies over \$100,000.00 to specifically cover prostheses subject to what may be available through the ADP program. One view of this was, however, that this proposed additional benefit may already be covered for those individuals who purchase the optional med/rehab benefit under the present policy.

RECOMMENDATION NO. 3

This section deals with this Panel's recommendation in dealing with brain impairment which is found in paragraph (e) of the definition.

The definition presently reads:

- "e) brain impairment that, in respect of an accident, results in,
 - i) a score of 9 or less on the Glasgow Coma Scale, as published in Jennett B. and Teasdale, G. *Management of Head Injuries*, Contemporary Neurological Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered

within a reasonable period of time after the accident by a person trained for that purposes, or

- ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose,”

The Panel has divided their recommendations with respect to these sections into two components. The first will deal with the 9 or less on the Glasgow Coma Scale portion of the definition.

The Panel recommends that subject to minor modifications that this section remain unchanged. The reason for our approach in this regard is the mandate of the Minister that permitted only fine-tuning of the definition. It was generally agreed amongst the Panel that setting the test at 9 or less on the Glasgow Coma Scale may result in unfairness to certain individuals and access to an increased medical and rehabilitation limit for other individuals who may not actually require it. The Panel points out that the Glasgow Coma Scale was not intended to predict long term outcome and that there are no clearly recognized medical studies that support a position that a score of 9 or less on the Glasgow Coma Scale will or will not result in catastrophic impairment in an individual. However, this Panel feels that in view of the limited time available to rework the definition of catastrophic impairment, and in view of the mandate that it should not pursue a replacement definition of brain impairment under this heading. The Panel recommends the following modifications:

- a) the words “within a reasonable period of time after the accident” should be removed from the definition. This provision has introduced some uncertainty into the application of the definition. It is the view of the Panel that the prime purpose of this definition is to reflect concern with causation; in other words, to require evidence that the reading on the Glasgow Coma Scale clearly related to the motor vehicle accident by looking at the timing of the reading. The Panel respectfully submits that a combination of the definition of accident together with the introductory words under the heading of brain impairment requires that there be a direct causal link between the brain impairment and the reading on the Glasgow Coma Scale and therefore the words are redundant.
- b) The second recommendation is that a new provision be added under brain impairment to cover situations particularly in rural hospitals where the Glasgow Coma Scale is

not administered. It is the experience of many of the medical practitioners on the Panel and indeed members who represent victims, that in the rural or less accessible areas of Ontario, often hospital staff or ambulance attendants will simply not administer a Glasgow Coma Scale. It was felt by the Panel that this resulted in an unfairness to those individuals who would clearly have had a Glasgow Coma Scale of 9 or less had that test been administered. Therefore, to cover this fairly limited situation, the Panel recommends that the following definition be added in under the present paragraph (e) as a second sub-heading:

“an episode of unconsciousness that is equivalent to a score of 9 or less on the Glasgow Coma Scale as set out in paragraph (i) herein, that is observed by a person trained for that purpose and is recorded in the insured person’s medical record”

The Panel points out that the important aspect of this provision is that essentially an individual only qualifies if there is an observed period of unconsciousness by, for example, the doctor in the hospital, and that the observation is recorded in the medical record. The medical members of the Panel are satisfied that there are various tests and observations that would appear in a chart that would allow another medical practitioner to make a clear determination that the injured person would have scored 9 or less had the test been administered. The Panel believes that this will not introduce uncertainty or litigation into the definition but will simply ensure that those individuals who should have qualified under the first part of the test, but for the location of treatment given in the hospital in which they were brought to get access to the level of benefits to which they are entitled. This recommendation received the support of the entire Panel.

The second part of the Panel’s recommendation deals with the Glasgow Outcome Scale. It is the Panel’s recommendation that what now appears as sub (e) (ii) as noted above, should now read:

“a score of 3, 4 or 5 on the Extended Glasgow Outcome Scale” as published in Wilson, J.T. Lindsay, Pettigrew, Laura E.L. and Teasdale, Graham, M. (1998) Structured Interviews for the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale: Guidelines for their Use: Journal of Neurotrauma, 15, page 573 to 585, according to a test administered more than six (6) months after the accident by a person trained for that purpose,

Since the original publication of the Glasgow Outcome Scale in 1975, as referenced in the current definition, two trends are clearly evident in clinical and research literature on brain injury. First, despite the development of a variety of other methods and scales for the evaluation of outcome after brain injury, the Glasgow Outcome Scale has remained the pre-eminent scheme for this purpose. Secondly, a variety of studies have consistently shown that the original Glasgow Outcome Scale lacks sufficient discrimination between the two mid-range points “severe disability” (a score of 3) and “moderate disability” (a score of 4). In effect it proves difficult in many instances to meaningfully differentiate between persons in these two categories when cognitive impairment or social and occupational disability are contrasted.

The clinical group that originally developed the Glasgow Outcome Scale recognized these two trends and recently published a description of a revised scale – the GOS Extended – and a companion objective assessment protocol for determining assignment to the various outcome categories. The Extended Glasgow Outcome Scale is therefore an expanded 8 point scale. A copy of an extract attached to this Report at Schedule “B” is a comparison of the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale in order to assist you in analyzing our recommendations that the present definition, relying on the Glasgow Outcome Scale, be amended to make reference to the Extended Glasgow Outcome Scale.

In reviewing many of the submissions from other stakeholders, this Panel noted that under the current definition there were individuals who would have a score of 4 (moderate disability) under the original Glasgow Outcome Scale and who would not qualify as being catastrophically impaired. This criteria might arbitrarily discriminate against some individuals who ought to be deemed catastrophically impaired.

Therefore this Panel felt it appropriate to attempt to evaluate making use of the Extended Glasgow Outcome Scale with a view to determining its potential applicability on our redefined definition of catastrophic impairment.

It should be noted that there was concern on the part of some Panel members that a move from the Glasgow Outcome Scale to the Extended Scale, would increase the number of individuals who may qualify as brain impaired victims without necessarily being catastrophically impaired. However, the GOS-E provides improved precision for determination of those injured individuals who are appropriately deemed to have suffered a catastrophic impairment. The group which would be included in the Level 5 proposed for catastrophic determination based on the GOS-E is made up of person who are: 1) not able to work, or, only in a sheltered or non-competitive position; 2) unable to participate (or,

rarely if ever) in regular social and leisure activities outside the home; 3) [demonstrate] constant and intolerable (daily) disruption of family relationships and friendships due to psychological problems.

The Panel suffered from lack of statistical information that would allow us to assess the affect that this recommendation would have on the system. While the Appendix attached setting out a comparison of the old and new scales does have some assistance in determining this, there were no statistics available to us which we could analyze and with any authority advise you as to what percentage of individuals would now become catastrophically impaired by virtue of adopting this recommendation. The best that the Panel could indicate was that while the change would result in more individuals being catastrophically impaired that the numbers did not appear to be large from a statistical perception. It is expected that many of those individuals who may be deemed to be catastrophic according to the GOS-E after six months, would have already been identified as catastrophic under the GCS or would ultimately be deemed catastrophic after two years according to the *AMA Guides'* 55% Impairment based on Chapter IV. Therefore, there may be only very minimal change in the number of individuals deemed catastrophic.

Therefore while the Panel in its entirety supported updating the definition to use the Extended Glasgow Outcome Scale which we understand will soon replace the Glasgow Outcome Scale in clinical settings, there was not a consensus among the Panel members to adopt this irrespective of what costing and statistical evidence may later show in terms of a potential premium increase.

Attached as Schedule "C" to this Report is a brief commentary from Ms. Carol Jardine of Royal SunAlliance which sets out some of her concerns with regard to the lack of statistical evidence and costing on this issue as well as on others.

Further, this Panel has been unable to address the question as to whether any of their recommendations will result in an increase to the cost of examinations under section 24 or in administration costs to the insurers as a result of insurers' exams and/or DACs being required for individuals seeking to qualify under these new definitions. Alternatively, the increased clarity and precision of the GOS-E provides improved direction for the catastrophic impairment assessment and determination. This clarity may result in reduced costs of assessments to determine status and fewer disputes.

RECOMMENDATION NO. 4

The next portion of the Panel's recommendations deals with the sections (f) and (g) of the definition. We do not recommend those two sections be re-worded. Rather, the recommendation is that a new section be added to deal with individuals who have significant trauma in the first two years of the accident but may ultimately not be found to be catastrophically impaired on an outcome basis under Sections (f) and (g).

Our second recommendation is that Sections (f) and (g) should not be read independently of each other. In other words, as the system is presently worded, an insured person can qualify for catastrophically impaired either on a 55% whole body impairment or under the mental and behavioral impairment. It is this Panel's recommendation that an insured person be entitled to add the two impairments so that a combination of the mental and behavioral impairment and the physical impairment under the 55% whole body definition result in a catastrophic impairment. It is this Panel's understanding that the only reason that this was not in the original draft was because it was believed that the *AMA Guides* did not provide a process for combining physical impairment with the mental and behavioral impairment. A review of the *AMA Guides* has indicated that in fact there is a process for combining them and it is this Panel's recommendation that failure to do that would result in a number of individuals who have clear catastrophic impairment as a result of a combination of physical and behavioral problems not otherwise be able to access needed attendant care, case managers, let alone medical and rehabilitation benefits.

With respect to the first mentioned recommendation under this heading, the Panel spent a great deal of time discussing the fact that there are individuals who are profoundly injured immediately after the accident and may require significant levels of attendant care (in excess of \$3,000.00 per month) within the first 104 weeks or may require somewhat more than \$100,000.00 in medical and rehabilitation benefits. These individuals are presently denied access to those levels of benefits because they do not qualify under any of the provisions of the catastrophic impairment definition other than possibly the 55% whole body impairment and for that assessment they must presently wait until their condition is stable or three years post-injury. It is this Panel's recommendation that these individuals should have access to a level of catastrophic benefits within the first two years subsequent to the accident **subject** to the requirement that at the 104 week (2 year mark), they must then reapply for catastrophic impairment determination based on one of the outcome based definitions such as the 55% whole body impairment. To clarify this process, we have put together an example.

An insured person is injured in a motor vehicle accident as a result of which he fractures both arms, both legs and a hip. Both his legs are placed in casts, both his arms are placed in casts

and he is discharged from the hospital within 10 days of the accident. This individual, in the present system, would not be deemed to be catastrophically impaired (unless he had a head injury) under any of the present provisions. Yet it cannot be considered a matter of debate that such a person may require a great degree of attendant care and possibly some significant rehabilitation in the early stages of the injury. Presently he has no case managers to assist him, access to only \$3,000.00 of attendant care and a possible concern that given significant funds being spent in medical and rehabilitation the cost will exceed \$100,000.00.

In this Panel's proposal, this individual would be found to be catastrophically impaired but only for a period of 104 weeks. During that 104 week period, subject to any MED REHAB DAC or other DAC processes and other tests of entitlement, he would have access to \$6,000.00 attendant care and the increased med rehab limits. However, it is anticipated that such an individual may not be catastrophically impaired if there is good recovery as one approaches the second year of the injury. This individual would therefore, at the 104 week mark, have to apply for a further determination of catastrophic impairment based on the *AMA Guides* either 55% whole body impairment and/or the mental or behavioral impairment.

This means that the second determination of catastrophic impairment would be outcome based with a view to looking at the long term. In the example we have given, it is the Panel's belief (relying primarily on our medical experts) that this individual, with even a reasonable or moderate level of recovery, would not qualify for catastrophic impairment under the outcome test. It is therefore, this Panel's recommendation that a third definition be added for which an individual could only apply within the 104 weeks after the accident, definition is as follows:

“an impairment or combination of impairments which result in an Injury Severity score of 15 or more using The Abbreviated Injury Scale, 1990, revision, updated 1998, The Association for the Advancement of Automotive Medicine, Illinois, U.S.A., and as recorded in the insured person's medical record by a person qualified for that purpose”.

Some explanation is required as to what the Injury Severity Score/the Abbreviated Injury Scale is. First, a copy of that document is attached as Schedule “D” to this report.

The Abbreviated Injury Scale (AIS) is a measurement tool that has been created by researchers and clinicians – by the Association for the Advancement of Automotive

Medicine. It has been adopted as a tool with which the severity of trauma (related to motor vehicle collisions) can be assessed and communicated in an objective manner.

Similar to the Glasgow Coma Scale (GCS) score, the AIS produces a score that directly relates to the nature and severity of trauma which occurs in a collision. Somewhat different from the GCS score, which reflects brain injury, the AIS assesses all types of physical injuries. This is irrespective of the mechanism of injury, *per se*, and does not take into account functional outcome or the need for specific types of therapy to address the injury. There is uniformity from Centre to Centre, from Hospital to Hospital and Country to Country with respect to the measurement the scale provides and the application of the data.

The AIS is also the scale that has been adopted by the Ontario Trauma Registry. It is utilized by the lead trauma centres across Ontario to assess injury and communicate severity of injury to the common data base for compilation and evaluation.

From the AIS, then the Injury Severity Scale is calculated. In brief, the individual AIS codes are used to compile the ISS – the three most serious scores from the seven body-systems are squared and then summed. One only scores the most severe injury within each of the seven system categories. The manual clearly describes how the AIS and the ISS should be calculated and compiled.

There is also substantial bibliography appended to the manual which demonstrates the literature within emergency medicine which backs up the findings of the ISS and its applicability across Centres.

The Panel is strongly in support of the use of the AIS and ISS as an objective measure which can be applied at the time of trauma and is currently utilized by all the lead trauma centres in Ontario. The ISS can also be applied retrospectively using the medical records from the hospital or trauma centre where the person was treated.

The specific thresholds which are utilized by the leading trauma centres and the Ontario Trauma Registry, are such that individuals with an ISS score of 15 or greater (for adults) and an ISS of 12 or greater (paediatrics, i.e. children 16 years of age or younger) are those with the most severe trauma and the highest likelihood of significant mortality and morbidity. Therefore, these individuals urgently require appropriate trauma care and tertiary medical services.

These are the individuals who will most likely require the most comprehensive medical rehabilitation services and attendant care services as a result of their injury. The appropriate

assignment of resources to these individuals and their issues expedites recovery and the rehabilitation process. It has been shown that early rehabilitation efforts reduce the time spent in rehabilitation and ultimately reduce the total cost significantly.

This is why we recommend that the ISS should be utilized as an objective score that can be universally applied to make those individuals with the most serious trauma eligible for appropriate rehabilitation and attendant care services in the early time-frames. The AIS and ISS, too, are a measurement that can be utilized for children as well as adults.

Further, there was no substantive information available to this Panel to support the number of individuals who would be affected by this latter recommendation.

It should also be pointed out that one of the Panel members did not support the recommendation that paragraphs (f) and (g) of the definition should be combined without clear statistical evidence to establish that a whole body impairment from a physical perspective combined with mental and behavioral impairment to total 55% would result in catastrophic impairment.

RECOMMENDATION NO. 5

The Panel also recommends that there be some amendment to paragraph 2 under the definition provisions of catastrophic impairment. Presently paragraph 2 requires that when considering 55% whole body impairment or mental or behavioral disorder definitions, that the definition cannot apply unless and we quote:

- “a) the insured person’s health practitioner states in writing that the insured person’s condition is stabilized and is not likely to improve with treatment; or
- b) three years have elapsed since the accident”

The observations of the Panel are that these sections simply do not work. Let us deal with the three years first. The first level of entitlement to attendant care and housekeeping benefits is limited to the first 104 weeks subsequent to the accident. In a number of cases, individuals with fairly serious injuries who would only qualify under the 55% rule, are running out of the \$100,000.00 med rehab limit in the post 104 week or even on some occasions in the pre-104 weeks after the accident. However, because their condition has not stabilized and is

likely to improve with treatment, they cannot apply for a catastrophic impairment designation until another year has elapsed. This has resulted in significant unfairness and even more importantly uncertainty for the insured as to what is going to happen to their treatment at the end of the 104 week mark or at when the \$100,000.00 runs out and until the determination of catastrophic impairment can be made. While insurers are doing their best to enter into agreements to deal with this situation, it is not satisfactory. The Panel therefore recommends that paragraph (b) to amended to read:

“two years have elapsed since the accident”

This results in the date for determination of catastrophic impairment coinciding with the date that benefits for non-catastrophic impairment terminate.

Secondly, it has been the experience of the members of the Panel that the insured person's health practitioner is reluctant to sign any document in which they must certify that the person's impairment is not going to improve with treatment as required under Section 2 (a). The reason for this is that the health practitioner is concerned that such a statement will result in there being no further access to medical and rehabilitation benefits irrespective of limits issues to their patient.

The Panel recognizes that stability is an issue and that there is no point in having a determination for catastrophic impairment applied for when clearly ongoing improvement is anticipated. The Panel therefore recommends that paragraph 2 (a) be amended to read as follows:

“the insured person's health practitioner states in writing that the insured person's condition is not likely to improve beyond catastrophic levels as defined herein”.

It was the Panel's view that an assessment for catastrophic impairment at the two year mark would not lead to incorrect outcomes in that the majority of the injuries that would be assessed at this point (55% whole body impairment) would have stabilized to the degree that outcome can be reasonably anticipated.

With respect to the costing issue, although actuarial numbers are not in, it was this Panel's view that while there may be higher up-front costs because of early access to full rehabilitation and medical benefits, recovery would be faster and more effective and thus result in reduced costs into the future. In addition, the requirement that the insured be re-

assessed at the 104-week mark would ensure that only those with outcomes that would be considered otherwise catastrophic would continue to qualify.

RECOMMENDATION NO. 6

The final area that the Panel attempted to deal with was the issue of pediatrics.

Firstly, we note that in the proposed draft of the *Statutory Accident Benefits Schedule* there are two recommendations made with which this Panel agrees.

The first is that if an insured person is less than 16 years of age at the time of the accident, or if they sustained a catastrophic impairment as a result of the accident, that all reasonable and necessary case manager expenses are provided. This Panel heartedly endorses the notion that a child requires a case manager whether or not they are catastrophically impaired. We also support the requirement that only case management services be approved for which a Treatment Plan has been provided so that it can subject to scrutiny and that the individual providing the services be qualified.

Secondly, this Panel agrees with the recommendations that a child who is under the age of 16 at the time of the accident be deemed to have purchased the optional medical rehabilitation and attendant care benefit.

However, while this results in children being able to get access to some needed benefits irrespective of catastrophic impairment, it still leaves children in other situations that will require a child to be assessed for catastrophic impairment.

The Panel had difficulty in reaching consensus on how that should be done. Some of the recommendations that were discussed were to provide a child under 16 for the first 104 weeks, access to \$6,000.00 limits of attendant care but then require at the 104 week mark to be assessed for catastrophic impairment.

This proposal reflects the concern of the Panel that children will continue to be deprived of attendant care in excess of \$3,000.00. They will only qualify for that under the present amendments if they are catastrophically impaired.

The Panel also looked at finding some way to allow the present definition of catastrophic impairment to apply to children. The *AMA Guides* and the Glasgow Coma Scale are not designed for children. However, it is almost impossible to come up with a definition to

replace the present wording that would work well for children keeping in mind that all the various functions continue to develop and change at least up until the age of 16.

Ultimately the Panel developed the following proposal:

Firstly, with respect to the early trauma cases, the Panel recommends that to that definition be added the wording:

“for an insured person who is less than 16 years of age at the time of the accident, an Injury Severity Score of 12 or more using the Abbreviated Injury Scale.”

As previously stated, the ISS score of 12 or more has been adopted by the Ontario Trauma Registry and the lead trauma centres across Ontario as the appropriate threshold for assignment of an individual to tertiary-level trauma care and acute care intervention.

These are the individuals who are at highest risk and serious morbidity. By appropriate assessment and intervention with medical and rehabilitation services, the process of stabilization and recovery can be expedited. Ultimately, the long-term morbidity and mortality can be minimized. Children, by virtue of their changing function through growth and development, are more susceptible to trauma leading to long-term problems, or acute medical decompensation. In particular, the relative force experienced by the child in a collision is a quantum leap greater than those of adults owing to the relative disparities in size and mass.

With respect to the other definitions, the Panel adopts the recommendations of the DAC Committee and The Advocates' Society as presented in their submissions to the Minister in 1998.

The Panel proposes that the following clause be added to the definition of catastrophic impairment for the purposes of children only:

“where the insured person is less than 16 years of age at the time of the accident, for the purposes of clauses (e), (f) and (g), a catastrophic impairment shall be an impairment that is sustained by the child which is deemed to be the most analogous to the impairments as presently described in those sections, taking into account the developmental consequences as they may reasonably be anticipated.”

It is necessary to make reference to the developmental consequences of impairments because as injured children grow they may come to be less functional and more disabled relative to their peers than they were when assessed at a time closer to their motor vehicle accident. Similarly, they may in fact improve in their level of functioning.

For example, if a 4 year old girl sustains a large lesion of the frontal lobe, her behaviour within one or two years of the accident may not be dramatically different from a normal child of that age. However, it is perfectly reasonable to anticipate that the child because of the injury, as she enters her teenage years, may present serious behavioral and management problems due to the loss of brain structure and function that had occurred years before and had not previously manifested itself.

CONCLUSION

In conclusion it should be reiterated that this Panel has worked long and hard to try to reach consensus in very difficult areas. We have attempted to address within the limited time available to us what areas of the definition of catastrophic impairment should be reworked or fine tuned to address areas in which the Panel believes that there was unfairness. It was unfortunate that we could not also address the critical question to the Government as to whether these recommendations would result in such an increase in premium that the Government mandate of premium stability would not be met.

We hope that this Report fairly reflects the issues and the concerns of the various stakeholders in the Panel with respect to each recommendation.

It should also be made clear that the recommendations of the Panel are **solely for the purposes of the Accident Benefits Schedule and are not being made with respect to the tort scheme whatsoever**. Should the Minister require recommendation with respect to any amendments or fine tuning from the tort perspective, that would require a different analysis and further time would be required.

All of which is respectfully submitted.

Dr. Robert D. Gates

Dr. Faith Kaplan

Dr. Harold Becker

Dr. Peter Rumney

Stephen Firestone

Steven Whitelaw

Philippa G. Samworth

Advisory Panel on Catastrophic Impairment

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Glasgow Outcome Scale Comparison

The following table provides a side-by-side comparison to the GOS and GOSE as described by Wilson, Pettigrew and Teasdale (1998)¹

Category	GOS Descriptor	Key Features	Category	GOSE Descriptor	Key Features
1	Dead		1	Dead	
2	Vegetative State	1. Unable to obey commands or say words	2	Vegetative State	1. Unable to obey commands or say words
3	Severe Disability	1. Assistance of another person necessary every day for some adl 2. Not able to shop without assistance 3. Not able to travel locally without assistance	3	Severe Disability - Lower	1. Needs frequent help or someone to be around most of the time
			4	Severe Disability - Upper	1. Does not need frequent help - able to be alone at home for up to 8 hours 2. Not able to shop without assistance 3. Not able to travel locally without assistance

1 Wilson, J. T. Lindsay, Pettigrew, Laura E. L., and Teasdale, Graham M. (1998). Structured interviews for the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale: Guidelines for their use. *Journal of Neurotrauma*. 15(8), 573-585.

Category	GOS Descriptor	Key Features	Category	GOSE Descriptor	Key Features
4	Moderate Disability	<ol style="list-style-type: none"> 1. Not able to work to previous capacity 2. Unable to resume regular social and leisure activities outside home (or, less than half as often as before) 3. Frequent or constant disruption of family relationships or friendships due to psychological problems 	5	Moderate Disability - Lower	<ol style="list-style-type: none"> 1. Not able to work, or, only in a sheltered or non-competitive position 2. Unable to participate (or, rarely if ever) in regular social and leisure activities outside home 3. Constant and intolerable (daily) disruption of family relationships or friendships due to psychological problems
			6	Moderate Disability - Upper	<ol style="list-style-type: none"> 1. Able to work or study but at a reduced capacity 2. Participates much less (less than half as often) in regular social and leisure activities outside home 3. Frequent but tolerable (once per week) disruption of family relationships or friendships due to psychological problems

Category	GOS Descriptor	Key Features	Category	GOSE Descriptor	Key Features
5	Good Recovery	<ol style="list-style-type: none"> 1. Able to work to previous capacity 2. Able to resume regular social and leisure activities outside home (at least half as often as before) 3. No psychological problems resulting in ongoing family disruption or disruption to friendships (or, only occasionally) 	7	Good Recovery - Lower	<ol style="list-style-type: none"> 1. Participates at least half as often as before in regular social and leisure activities outside home 2. Occasional disruption of family relationships or friendships due to psychological problems 3. Other problems relating to the injury (headache, dizziness, tiredness, sensory sensitivity, slowness, memory failures, concentration problems) affect daily life
			8	Good Recovery - Upper	<ol style="list-style-type: none"> 1. Able to work to previous capacity 2. Able to resume regular social and leisure activities outside home 3. No psychological problems resulting in ongoing family disruption or disruption to friendships



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Date : September 27, 2000

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From: Carol Jardine, Vice-President, Claims

RE: Advisory Committee on Definition of Catastrophic Impairment

Dear Phillipa:

Thank you for your facsimile transmission of September 21st that enclosed the next draft of the Committee's report on the definition of Catastrophic Impairment.

In reviewing the recommendations contained in the draft report to the Minister, I was drawn back to the mandate of the panel. As you so eloquently state, the mandate was to review the definition of Catastrophic Impairment so that any requisite "fine tuning" can be considered. From those words I took the mandate to be one of little change to the automobile product, in order to maintain the rate stability of the Ontario Automobile product. In reviewing the recommendations put forward by the Committee, I believe that there is tremendous possibility that if even just some of the recommendations are accepted the committee will have de-stabilised the automobile insurance product for the future.

Insurance companies can administer any automobile product mandated by the Government as is evidenced by the insurer's ability to adapt to the changes in the last 10 years. Whether it is OMPP, Bill 164 or Bill 59 the consumers of Ontario have been more than satisfied with the services administered by the insurers, as evidenced by the results of the Claimant Satisfaction surveys and reduction in complaints to the Ombudsman. It is just a matter of price. How much will it cost and will consumers pay the price?

We certainly do not want to create another insurance crisis in the province of Ontario.

The Committee has been challenged by the lack of data to support the number, of victims who the Doctors, rehabilitation services and plaintiff lawyers say are allegedly under serviced by the current product. In reviewing all the submissions, only that of the Ontario Brain Injury Association dated November 14th, 1997, contained a reference to an actual accident victim, a child whose mother relayed specific concerns regarding provision of the service. However, Andre Langlais at the end of her submission indicated that her daughter had recovered well and thanked the Head Injury Association for their assistance. They also felt that their insurance representative had been reasonably helpful. We recognise the needs of children.

All the other submissions referenced hypothetical victims and were subjective complaints of individuals or corporations whose livelihood was dependent upon having additional access to revenues.

It is difficult to get a substantive number of the individuals who require the treatment modalities only available if deemed "catastrophic impairment" today, and those who would have access to the system if a broader interpretation as recommended in your report were adopted. Throughout the Committee's meetings, I continually requested from the Doctors, and plaintiff lawyers real life examples of individuals currently deemed catastrophic, and those that exhausted their benefits and we seemed to run across very few. No one at the table was able to provide numbers, only stories. Without the numbers, I am unable to make a substantive decision regarding the Committee's recommendations. In fact, I believe that the Committee's recommendations have done more than fine tuning the definition, and have basically rewritten the terms of the coverage to greatly enhance the number of people who would benefit from this catastrophic compensation.

We do know that the DAC system is working. That people who believe that they are catastrophically impaired, and are denied the appropriate benefits by their insurer have access to the DAC system. In the last 3 years a total of 173 adults and 18 children have requested catastrophic assessments in the DAC system. Of that number, 125 adults and 14 children had an outcome determination that they were catastrophically impaired. That leaves 48 adults and 4 children who were deemed non-catastrophic by DAC system. If the objective of the Committee, was to fine tune the Catastrophic Impairment definition, to allow to the 48 adults and 4 children, access to the \$1 million in benefits, then we should have looked at that data and determined why these individuals were not catastrophic. Instead we are working from a known system that did not work for 48 adults to an unknown system that would greatly increase access for a much larger number of people.

As an insurer I can deliver any level of benefits the government and the consumers of Ontario are prepared to pay for. I do believe that these recommendations are not economically feasible considering the increasing cost of operating an automobile in the Province of Ontario.

Recommendation #1

Supported

Recommendation #2

I would support us determining the costing of Recommendation #2 to include the loss of both arms or both legs, or both an arm and a leg.

I vehemently disagree with Mr. Firestone's suggestion that Recommendation #2 be expanded to include either an arm or a leg. Mr. Firestone's argument is for prosthesis requirements, and I have been unable to obtain any substantive information to suggest that a need exist. AMA Guides for whole body impairment do not support single limb amputations. I would therefore support the Recommendation #2 as drafted, along with your last paragraph.

Recommendation #3

In Recommendation #3, it is the first part of the Recommendation that has changed, which inserts "an episode of unconsciousness...." and supports the mandate of fine-tuning. I support the change.

However, the second part of the committee's Recommendation dealing with the Glasgow Outcome Scale, and moving to the Glasgow Outcome Extended Scale including a score of 3, 4 and 5 will greatly increase the number of individuals who may qualify as brain impaired victims, without being catastrophically impaired. My research is based on the material supplied by the Doctors. Specifically the Journal of Neuro Trauma Volume 15, November 8th, 1998, specifically links the GOS and GOSE. That paper does not support the use of the GOSE, but states "the advantages of the GOS remain its simplicity, wide recognition and the fact that differences and disability are clinically meaningful. Provided that the purpose in limits as well as the benefits of the GOS are appreciated, it can continue to have a central place in the assessment of head injury outcome". I cannot support the replacement of the GOS for the GOSE.

In reviewing the distributions of GOS ratings, versus potential GOSE ratings in Table 2 of the paper, it would suggest an additional 18% of the brain-injured victims would be eligible for benefits according to brain impairment. If we consider current trauma registry data of 8,788 brain-injured victims; we potentially increase the number of brain impairment victims to over 1600 per year. With each victim eligible for \$ 1million plus double the attendant care, the increase in cases, would eliminate any attempt for rate stability.

In the papers provided by the doctors, I was unable to provide any academic support for the use of the Glasgow Outcome Extended Scale versus wide support for the Glasgow Outcome Scale. I therefore feel that we should not be making "new ground" and should not significantly broaden the definition outside of accepted medical practice. I can not support this part of the recommendation.

Recommendation #4

We have continually pursued medical information and statistics in order to determine the number of theoretical individuals that would fall into the examples you have mentioned. Unfortunately, myself included, have been unable to locate or quantify the number of individuals. It is not the individual, who consumes the \$100,000 in excess of Ministry and Health deemed benefits, but the corporate or individual service providers and usually non-specific health practitioners who are billing outside Ministry of Health standards. I do not believe it is the purpose of the Minister's Committee to support a 3 tier medical system, so that over-funding is provided to automobile accident victims while those injured at home or work are denied or services.

I require substantive information to support the number of individuals who may be affected, and the ability for the motoring public to bear the brunt of the cost, before insurers would be prepared to consider Recommendation #4.

Recommendation #5

Cost is the only issue, and if acceptable I support the recommendation.

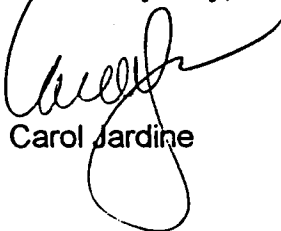
Recommendation #6

I fully support the need for appropriate treatment in paediatric situations, and again require costing data.

I am not comfortable with the AIS - Abbreviated Injury Scale and the lack of expertise and research in its ability to determine entitlement to benefits. This is new ground and more than fine – tuning the definition.

Please incorporate my comments into the report.

Yours very truly,



Carol Jardine