Changes to the Insurance Act as of September 1, 2010: The Good, the Bad, and the Ugly

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On September 1, 2010, the Ontario Liberal government brought in more changes to our already much tinkered-with automobile insurance regime. While some changes are positive for those who have been injured in automobile crashes, the majority of the changes are intended to save the insurance industry money, and by extension, deprive injured people of additional rights and benefits that were available previously under their policies.

The Good:

Fatality claims:

Under section 267.5(8.1.1) of the Insurance Act, deductibles for fatality claims are now eliminated. This change will put more money into the hands of family law claimants who have lost a family member as a result of a motor vehicle collision. Take an example:

> **Grandmother with a spouse, 2 siblings, 3 children, and 5 grandchildren, dies in a motor vehicle collision. Under the previous legislation, this claim would include $150 000.00 in deductibles (ten $15 000.00 deductibles).**

If this same claim was to be put forward after September 1, 2010, then that $150 000.00 stays in the hands of the family members.

Although there is no question that this change in the legislation is very positive for those who lose a family member in a car crash, the vast majority of auto claims do not involve fatalities, so this concession made by the insurance industry is not as costly as other concessions that would have put more money in the hands of all injured people, such as lowering the deductible on non fatality claims from $30 000.00 to $15 000.00.

Catastrophic impairment claims:

For seriously injured people, it is essential to be deemed to be catastrophically impaired, as qualifying under this definition allows an insured person to access $1 000 000.00 in medical and rehabilitation benefits (as opposed to $50 000.00), and also, it entitles a person to a lifetime of attendant care and housekeeping benefits.

So far, the government has not chosen to amend the definition for catastrophic impairment, which appears in section 3(2) of the SABS. To be declared catastrophically impaired, you still automatically quality with a Glasgow Coma Scale rating of 9 or less (section 3(2)(d)(i)), or if you are suffering from paraplegia or quadriplegia (section 3(2)(a)), or have suffered a total loss of vision in both eyes (section 3(2)(c)).

Another positive change that came on September 1st, 2010 is that a person doesn't need to lose two limbs in order to be declared catastrophically impaired. Section 3(2)(b) states that a person will be catastrophically impaired who has sustained:

> **"(b) the amputation of an arm or leg or another impairment causing the total and permanent loss of use of an arm or a leg"**

This expansion of the criteria to be declared catastrophically impaired is indeed a good thing, as now more people will be able to be automatically deemed catastrophically impaired, without having to establish that they are suffering from a 55% whole person impairment.

Accountant Expenses:

Another positive change in this legislation is that under section 7(4): "The insurer shall pay an expense incurred by or on behalf of an insured person for the preparation of a report for the purpose of calculating the person's income from employment or self-employment". However, the expense must be deemed to be "reasonable and necessary for the purposes of determining entitlement to an income replacement benefit, and the insurer is not required to pay more than $2500.00 for the report. Nonetheless, this change is a positive change, as it mandates that the insurer must pay for an accountant selected by the insured, to calculate the insured's entitlement to payments for income losses. Also note that income replacement benefits are now calculated at 70% of gross pre-accident income, as opposed to 80% of the insured's net pre-accident income (section 7(2)(2)).

This is the end of the good stuff.

The Bad:

"Incurred Expenses" defined:

Under the previous legislation, an insurer only had to pay for expenses that were incurred, but as "incurred" was not specifically described, there was no problem in establishing that, for example, a husband had provided housekeeping services for his injured wife, and that his time in performing these services was an "incurred expense". The new changes, however, narrow down the situations when services such as housekeeping assistance performed by a spouse can be deemed an "incurred expense".

Section 3(7)(e): defines "incurred expense" as:

1. The insured must receive the goods or services,

2. The insured has paid or promise to pay the expense, or is legally required to pay it AND
3. The recipient of the payment provides the goods or services as part of their regular occupation or has suffered an economic loss to provide the goods or service

It is part (3) of this definition that is the most problematic. To go back to the example of the husband providing housekeeping services for his wife, if he spends his evenings cleaning after working full time at his regular day job, he may find it difficult to prove that he has suffered an "economic loss" performing the housekeeping services, and therefore, he may find it difficult to be paid for those services.

This definition of "incurred expense" also applies to attendant care claims. Previously, family members could provide attendant care services, and apply for the benefit, being confident that their services would be paid for. Often, it is difficult for the injured person to pay for services such as attendant care up front, so having family members provide the attendant care (as opposed to professional health workers) was an ideal way to manage attendant care costs. However, now that only people suffering an economic loss can be reimbursed for attendant care expenses, it will require creativity on the part of counsel or those applying for the benefit to demonstrate they have suffered an economic loss. For instance, stay at home spouses may now want to argue that although they were home full time before their spouses were injured, after their spouses became injured they would have returned to the work force, but were unable to as a result of the need to provide attendant care to their injured spouses. In this fashion, the stay at home spouse should still be able to demonstrate that he/she has suffered an income loss when choosing to continue to stay at home to provide attendant care to his/her injured spouse.

Another important point to note regarding the requirement to have "incurred expenses" in order for attendant care to be paid for is that the rates allocated to attendant care expenses under Form 1 of the Statutory Accident Benefits Schedule (SABS) do not reflect the reality of the cost of hiring professional health care providers to look after an injured person's attendant care needs. Before the September 1st changes, it was the perfect situation for family members to assist, as their hourly rates for providing attendant care were generally lower than the rates charged by professional healthcare workers. Now, injured people may have no choice but to hire professional healthcare workers (if they can afford to), and in this circumstance, the monetary allowances provided for under Form 1 of the SABS will not likely be enough to cover the needs of a catastrophically injured person.

More Bad – Compounded Interest Rates Reduced:

Under the previous legislation, insurers had to pay a punitive compounded interest rate of 2% on all overdue payments. Under the September 1st changes, section 51(2) stipulates that the interest rate for overdue payments will now be reduced to 1%. So,

insurers just saved 50% on the amount that they are going to have to pay in the future for overdue or outstanding payments.

The Ugly:

Reduction of Medical and Rehabilitation Policy Limits:

Previously, non catastrophically injured people had up to $100 000.00 in medical and rehabilitation coverage to assist them as they recovered from their injuries. In addition, any expenses from doctors who assessed them were paid for under section 24 of the SABS, and therefore, the assessment expenses were not deducted from the $100 000.00 policy limits.

Now, section 18(3)(a) of the SABS has reduced the maximum amount paid to a non catastrophically injured person from $100 000.00 to $50 000.00. As well, if the insurance company is required to pay for any medical assessments on behalf of the injured person, those assessment costs are deducted from the $50 000.00 (section 18(3)(5)). Although $50 000.00 may seem like a lot of money, it will not take long for injured people to burn through the $50 000.00.

For example, if you are dealing with a person who suffers from chronic pain, that person likely has a whole team of health care providers to assist him or her. The injured person likely has a case manager, a rehabilitation therapist, an occupational therapist, a psychologist, a massage therapist, a physiotherapist, etc. All of these services cost money, and for non catastrophically injured people who are heavy users of medical services, they will likely run out of money for services quickly.

Some service providers may be willing to work on a deferred fees basis, where they wait to be paid until the case resolves. Be prepared, however, for the provider to charge a punitive interest rate if the provider if being asked to wait extensive periods of time to be paid. Clearly, the main concern will be ensuring that injured people who are not deemed to be catastrophically impaired are able to continue to receive necessary medical and rehabilitation services. Advances from the tort insurer may be available, or alternatively, if the accident benefits insurer feels that increased access to medical or rehabilitation coverage will increased an insured's function enough to return to work or lessen attendant care needs, then the accident benefits insurer may be prepared to pay more than the $50 000.00 limit if it makes economic sense to do so.

More Ugly: No housekeeping benefits or caregiver benefits for non catastrophically injured people:

Section 13(1) of the SABS stipulates that caregiver benefits are now eliminated in non catastrophic cases. In addition, section 23 of the SABS stipulates that housekeeping benefits are now eliminated in non catastrophic cases.

The problem that injured people will encounter with the elimination of these benefits, is that they cannot afford to have other service providers come in and perform these services, particularly when the injured people are already often struggling with a reduced income as a result of their disability.

Even more Ugly: The Minor Injury Guideline (the "MIG"):

Section 3(1) of the SABS brings a new creature to the people of Ontario… the MIG (Minor Injury Guideline). The purpose of this guideline is clearly to capture the majority of the smaller injury claims, and drastically limit the amount of accident benefit resources being spent on those claims.

Section 3(1) defines cases falling into the MIG as follows:

> **"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"**

The various terms appearing in the definition of "minor injury" under section 3(1) are also defined under section 3(1):

"**Sprain**" defined as: Partial but not complete tear of ligaments, tendons or muscles

"**Strain**" defined as: Injury to one or more muscles including a partial but not complete tear

"**Subluxation**" defined as: Partial but not complete dislocation of a joint

"**Whiplash associated disorder** defined as: a whiplash injury that "does not exhibit objective, demonstrable, definable and clinically relevant neurological signs"

Section 18(1) of the SABS states that if a case has been deemed to fall into the MIG, then there are only $3500.00 in medical and rehabilitation benefits available to the injured person. If a person has not been deemed to have suffered a "minor injury", then the injured person would have up to $50 000.00 available in medical and rehabilitation benefits. This limit on medical and rehabilitation expenses under the MIG is quite radical. Previously, a "minor injury" would still have had up to $100 000.00 available in medical and rehabilitation benefits. Now, people who have suffered "minor injuries" clearly have very limited benefits.

The MIG poses many concerns. What if a person is still suffering from chronic pain after the $3500.00 has been used up? In a chronic pain scenario, the insurer may not fund additional medical or rehabilitation benefits if the case has already been classified as "MIG". Massage therapists, chiropractors, and physiotherapists cannot be paid for through OHIP. What will a "minor injury" insured do? It is unlikely that a

"minor injury" claim will obtain legal representation, as the damages will likely be too small to warrant a lawyer's involvement in a lawsuit, so the person who has suffered a "minor injury" will likely not be able to obtain legal representation.

There are a few situations where a person who has an apparently "minor injury" may be able to avoid the application of the MIG. Section 18(2) specifies that insureds who have suffered a psychological injury will not be exposed to the $3500.00 cap on medical and rehabilitation funding. In addition, if there is compelling evidence of a pre-existing condition (which can only be supplied by a treating physician or other healthcare provider), then the MIG will not apply, as a person predisposed to injury will likely have a more medically complicated case. But beware: if counsel needs to demonstrate that a person was predisposed to injury in order to escape the MIG and have access to greater medical and rehabilitation funding, then expect that those same pre-existing injuries may cause you major headaches and obstacles in your tort claim. In other words, if you have successfully demonstrated that your client has a pre-existing condition in the accident benefits context, you are going to be stuck with that same evidence of pre-existing injury in the tort context, which will no doubt create causation challenges in your tort claim.

More Ugly: Limits on Assessment Costs:

Section 25(5)(a) of the SABS stipulates that all medical and insurer assessments or examinations will be capped at $2,000.00. This section applies to insureds and insurers equally. In my experience, insurers were the greatest culprits at running up huge assessment costs in the course of evaluating a case, so in some respects, section 25 of the SABS saves insurers from themselves! However, obviously the amount of money available to have legitimate injuries assessed by specialists has now been reduced. In addition, whereas previously assessment costs submitted by an insured were paid by the insurer separate and apart from any medical and rehabilitation expense limits, now section 18(5) stipulates that assessment costs are to be deducted from an insured's medical and rehabilitation policy limits. ($50 000.00, or $1 000 000.00 in the case of catastrophic impairment claims.)

It would appear as though an insured can still obtain assessments at a cost greater than $2000.00, but that the insurer will only be required to pay up to $2000.00 for the assessment.

Under section 25(1)(5), it would appear that section 25(5)(a) does not include the fees charged by a healthcare provider in preparing an application under section 45 for a catastrophic impairment assessment.

The other most unfortunate aspects of section 25 are that the requirement for insurers to send the disputed benefit to an independent assessor has now been eliminated, and the opportunity for an insured to obtain a rebuttal report at the expense of the insurer has also now been eliminated.

With respect to Catastrophic Impairment (CAT) assessments, section 45 stipulates that only a physician can complete a CAT assessment, although section 45(2)(2) confirms that a neuropsychologist can also complete a CAT assessment. It is extremely surprising that psychologists would otherwise be precluded from performing CAT assessments.

When determining how to fund a CAT assessment if you cannot obtain sufficient funding from the insurer, consider paying for the CAT assessment yourself, and then disbursing it as a tort expense, getting an advance from the tort insurer, or using a third party lender to fund the disbursements (but watch out for the interest rates they charge!!)

More Ugly: Reduction in Attendant Care Costs for Non-Catastrophic Cases:

Whereas previously, Attendant Care Benefits were available in non Catastrophic cases for up to $72 000.00 over two years, section 19(3)(2)(ii) now specifies that Attendant Care benefits have been reduced to $36,000 over 2 years for Non CAT cases. Section 25(1)(4) also specifies that Attendant care assessment forms can only be completed by an RN or OT, and that the insurer will pay the fees associated with the assessment under this section.

When handling an injured person's accident benefits claim, also make sure you determine if the insured person purchased the optional benefits coverage under section 28 and 29 of the SABS. Coverage under section 28 provides for expanded medical and rehabilitation coverage up to $100 000.00 in non catastrophic cases, increased income benefits, housekeeping paid even in non catastrophic cases, caregiver benefits, increased attendant care benefits and dependant care benefits. In addition, and insured can purchase a premium that reduces the deductible recovered by the at fault driver from $30 000.00 to $15 000.00. Please also note section 68 that stipulates the transition provisions. If the insured was injured after September 1, 2010, but the insured's policy has not yet renewed at the time of the collision, then the insured is deemed to have purchased the optional benefits referred to in section 28 and 29 of the SABS.

While it is certainly frustrating to have to pay additional premiums for coverage that was in place already (without having to pay additional premiums), the September 1st changes now force policy holders to decide if they want increased coverage, and to pay the additional premiums to get that coverage.

Fortunately, the cost of the additional premiums is not excessive. You need to contact your broker or an insurance company directly to determine if the additional premiums that will be charged for housekeeping benefits, increased attendant care benefits, increased income replacement benefits, dependant care, and increased medical and rehabilitation benefits are worth the increased access to benefits. It is my understanding that the premium increases for these additional benefits will not be significant, so make sure you consider this issue carefully when it is time to renew your auto policy! From now on, when you see a new client who has been injured in a motor

vehicle, make sure you make inquiries to see if your client purchased the additional coverage. We may find more litigation evolves in the future against brokers who fail to inform clients of the advantages of purchasing these optional coverages.