

**THE ROAD AHEAD FOR IMPECUNIOUS VICTIMS**  
**Paper originally presented to the Carleton County Law Association on May 25<sup>th</sup>,**  
**2010**  
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**A. Introductory Comments and General Overview of Benefits**

Regulation 43/10 (released March 3<sup>rd</sup>, 2010) comes into effect on the 1<sup>st</sup> of September, 2010. It will radically reduce accident benefits especially for non-catastrophic injury victims unless optional coverages are purchased. Obtaining optional coverages has now become very important for the protection of accident victims even though only approximately 3% of insured persons purchased optional coverages historically. Recommending optional coverages to clients may be important, especially for brokers.

The changes made by the Regulation are summarized in the attached chart entitled “Statutory Accident Benefits”. Although that is a detailed summary a very general overview of the changes are as follows:

**Substantive Benefit Changes - Overview**

- unless optional coverages are purchased, accident victims will receive **Medical and Rehabilitation Benefits** for non-catastrophic injuries reduced from \$100,000 to \$50,000 (with the costs of assessments deducted therefrom). CAT Med Rehab limits are the same = \$1 million (with the costs of assessments deducted therefrom);
- **Minor Injuries Guidelines** (MIG) replace the PAF with a limit of \$3,500 (including assessment, examination and report costs) which can be increased to \$50,000 if there is compelling evidence that a pre-existing condition prevented maximal recovery;
- **Attendant Care** not available for Minor Injuries (MIG)
- **Non-Catastrophic Attendant Care** is reduced from \$76,000 to \$36,000. CAT Attendant care limits are the same - \$1 million;
- **CAT definition** now only requires one limb to be amputated or permanently impaired. In addition, 55% WBI and extreme or marked impairment cases can't be applied for until 2 years after the accident;

- **Housekeeping Benefits** only available for *Catastrophic* injuries;
- **Care Giver Benefits** only available for *Non-Catastrophic* injuries.

### **Procedural Changes - Overview**

- Form 1 Assessment for Attendant Care form may be completed only by an OT or RN;
- CAT examination and application can only be completed by a physician or neuro-psychologist;
- Cost of Treatment and Assessment Plan is CAPPED at \$2,000 including the cost of reports;
- OCF-22 and OCF-18 are combined into one form called Treatment and Assessment Plan, and must be signed by the insured;
- definition of “*Incurred Expense*” is restrictive and will harm impecunious victims;
- insurers shall not pay for Lifecare Plans;
- weekly income replacement benefits (IRBs) are calculated as 70% of gross income to a maximum of \$400 per week vs tort measure of 80% of net up to Trial. Interaction not clear. No time restriction even for MIG injuries on receiving IRBs;
- assessment costs taken out of the limited Med Rehab benefit.

### **Optional Benefits - Two Levels**

- the first level brings the benefits up to the same limits, generally, as they were under previous SAB regime (Reg. 403/96);
- Rolls Royce benefits can be acquired which will significantly increase attendant care and medical and rehabilitation benefits;
- increased IRBs are also available as they were before this Regulation.

## **B. POWER POINT DISCUSSION BY PANEL**

**C. A MORE DETAILED REVIEW OF THE CHANGES**

**MEDICAL AND REHABILITATION BENEFITS (“MED REHAB”)**

**Deduction of Examination, Assessment and Report Costs from “Med/Rehab” Limits**

An unfortunate change is the deduction of the costs of assessments, examinations and report costs from the victim’s med rehab benefits limits in accordance with s.18(5). This deductibility applies to all three categories of claims ie. Minor Injuries, non CAT and CAT injuries. The said requirement to pay for the costs of assessments, examinations and reports has only two exceptions. A s.44 (insurer’s I.E.) assessment is to be paid for by the insurer as is the accounting fee relating to income replacement calculations (s.18(5)(a)(b), capped at \$2,500).

**1. Minor Injury Definition and Minor Injury Guideline (“MIG”)**

**Med Rehab Issues:**

This “Minor Injury” level replaces the Pre-Approved Framework (PAF) regime under Reg 403/96. It is subject to the release of the formal Minor Injury Guideline establishing the ‘treatment framework’ for such injuries on or about the 28<sup>th</sup> of June, 2010. It does not appear that it is necessary to consider WAD I or II categories but rather the definition includes collectively whiplash associated disorders (WAD).

**“Minor Injuries” is defined under s.3(1) as meaning a “sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequella”.**

“Minor Injury Guideline” is defined as meaning “a guideline:

- (a) **that is issued by the Superintendent under s.268.3(1.1) of the Act and published in the Ontario Gazette; and**
- (b) **that establishes a treatment framework in respect of one or more minor injuries”.**

The definition of “*minor injury*” also has some of the words defined in it. For example:

- (i) **a “sprain” in s.3(1) is defined as meaning “an injury to one or more tendons or ligaments or to one or more of each, including a partial but not a complete tear;**
- (ii) **“strain” is defined as meaning “an injury to one or more muscles, including a partial but not a complete tear”;**
- (iii) **“subluxation” is defined as meaning “a partial but not a complete dislocation of a joint”;**
- (iv) **“whiplash associated disorder” is defined as meaning “a whiplash injury that (a) does not exhibit objective, demonstrable, definable and clinically relevant neurological science, and (b) does not exhibit a fracture in or dislocation of the spine”;**
- (v) **“whiplash injury” is defined as meaning “an injury that occurs to a person’s neck following a sudden acceleration-deceleration force”.**

The restricted maximum Minor Injury med rehab benefit of **\$3,500** [s. 18(1)] [*from which assessment, examination and reports costs are to be deducted - 18(5)*] can be increased to **\$50,000** if “*compelling evidence exists that there is a pre-existing condition that will prevent maximal recovery*” [s. 18(2)].

Section 18(2) reads:

**Despite subsection (1), the \$3,500 limit in that subsection does not apply to an insured if his or her health practitioner determines and provides compelling evidence that the insured person has a pre-existing medical condition that will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the \$3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.**

**The Importance of Pre-existing Conditions and Separate Injury Arguments:**

Counsel in the future will want to consider soliciting opinions from their own (“his or her”) client’s health practitioner focusing on the “*pre-existing medical condition*” of a victim in order to increase the limit to \$50,000. The Regulation does not require any *diagnosed* pre-existing condition nor does it limit pre-existing disposition so that the use of the *thin skull theory* might not be of assistance. There seems to be nothing to prevent the *aging* of accident victims as being a pre-existing condition.

As a side note, it is interesting to wonder if Plaintiff’s counsel retains an independent health practitioner such as a specialist as to whether that will qualify as “his or her health practitioner”? Moreover, what if the pre-existing condition opinion arises in a s.44 Independent Medical of the Insurer? Will that be admissible to prove the pre-existing medical condition?

The definition of “*Minor Injury*” may plague Plaintiffs as the definition deals with soft tissue injuries that can be sustained in the same accident from which severe permanent psychological or psychiatric conditions develop such as Post Traumatic Stress Disorder, Chronic Pain Syndrome etc. In addition many long term or permanent conditions related to soft tissue injuries such as myofascial pain and related syndrome, arthralgia etc can develop into debilitating permanent and disabling conditions. Will these be treated as separate injuries?

The definition of Minor Injury will now yield a host of litigation where Insurers will argue that these debilitating permanent conditions are limited to \$3,500 in MR benefits

because of the words at the end of the Minor Injury definition - ... ***“and any clinically associated sequella”***. Arbitrators and/or Courts will have to determine if the psychological injury is a *separate injury* (as Plaintiffs will argue) or an “associated sequella” (which Defence counsel will argue). In addition Arbitrators and/or courts will hear arguments that myofascial pain Syndrome and Chronic Pain Disorders were related to *“pre-existing medical conditions”*.

It is important to realize that a determination of “pre-existing medical condition” may attract the higher Non CAT \$50,000 limit for Med Rehab but will probably not change the Minor Injury into a Non CAT or CAT injury. The importance of this is that Minor Injuries victims do not have access to Attendant Care [s.14(2)] or other benefits restricted to CAT designated victims (eg. Care giver benefits, Housekeeping benefits etc.). Conversely, if it is determined that a long term injury such as Traumatic Stress Disorder is a *separate* permanent injury - that may move the SAB categorization of the injuries into the Non CAT or even the CAT category of entitlement (where there are many more benefits available as set forth below).

For minor injuries, in-home assessments are not allowed [s.25(2)].

As indicated above, the costs of assessments, examinations and reports can erode the \$3,500 limit so that the net Med Rehab benefit becomes even more modest. 18(5).

## **2. Non Catastrophic Injuries**

**Definition:**

There is no definition of Non Catastrophic Injuries per se. The definition of this level of injury is that the injuries do not fall into the “*Minor Injury*” or “*Catastrophic*” definitions in Reg 34/10. Non CAT injuries are the wasteland between the two definitions.

**Monetary and Time Limits of Coverage:**

With respect to non-catastrophic injuries the Med Rehab benefit has been reduced to **\$50,000** (down from \$100,000 in the previous SAB regime - Reg. 403/96) including the deduction of assessment, examination and report costs (s.18(5)). The non-catastrophic payout continues to be for 10 years after the accident if the victim was at least 15 years old (s.20(1)(a)) or if less than 15 when injured the victim is entitled to benefits until his 25<sup>th</sup> birthday (s.20(1)(b)).

**Budgeting:**

Budgeting of the \$50,000 limit may become a serious issue for injured victims and their counsel if there is a possibility that the injuries are potentially “catastrophic”. Obviously a severely injured victim will probably go through the \$50,000 limit of non-catastrophic benefits fairly quickly especially when deducting assessment, examination and report costs under s.18(5). With the \$50,000 gone quickly it may be a challenge to severely injured victims to obtain the funds (\$8,000 and \$10,000) for a catastrophic assessment which assessment costs have to be taken from the \$50,000 limit.

If counsel and victims are not careful those limits will be gone before the costs of such a catastrophic assessment and application can be dealt with. Budgeting therefore becomes important. This is particularly the case where the potential catastrophic impairment relates to the catastrophic impairment definition under s.3(2) (e) and/or (f) *which must be applied for ONLY two years post accident, unless it includes a brain*

*injury - [55% whole body impairment and marked or extreme impairment due to a mental or behavioral disorder].* All other categories of “catastrophic” designation can be applied for immediately following the accident if appropriate.

One can imagine injured victims being unable to afford to apply for catastrophic impairment level of benefit even though they might qualify otherwise. If there is no related tort action, victims will be left on their own to finance treatment. If there is a related tort action, victims may obtain financing on their own, through family, counsel, or through tort specific financial institutions such as Lexfund, Bridgepoint etc.

Budgeting becomes essential. In fact, it might be prudent for counsel to obtain an assessment of an obvious case early on if possible before the Non CAT limit is gone to ensure that the evidence is available for the CAT application. The use of OHIP created evidence such as hospital or family physician clinical notes, records and reports may be necessary to base a CAT application where the Med Rehab limits are gone.

### **3. Catastrophic Impairment**

#### **Med Rehab Issues:**

Catastrophic is strictly defined in the Legislation and includes “*paraplegia, quadriplegia*” and has been amended to include the loss of only one limb as opposed to two as required under the old Legislation. Catastrophic is defined in s.3(2) to 3(6) as follows:

**For the purposes of this Regulation, a catastrophic impairment caused by an accident is,**

- (a) paraplegia or quadriplegia;**

- (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*;
- (c) the total loss of vision in both eyes;
- (d) subject to subsection (4), brain impairment that 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* according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or
  - (ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennet B. and Teasdale, G., *Management of Head Injuries* according to a test administered more than six months after the accident by a person trained for that purpose;
- (e) subject to subsections (4), (5), (6), an impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4<sup>th</sup> edition, 1993, results in a 55 per cent or more impairment of the whole person; or
- f) subject to subsections (4), (5), (6), an impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4<sup>th</sup> edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

CAT level of injuries continue to provide up to \$1 million coverage. However, as noted above that \$1 million includes now the cost of assessments, examinations and reports [s.18(5)].

One of the clinical changes in medical and rehabilitation applications for catastrophic designation is that the forms must be filled out by a physician for the catastrophic application unless the impairment is a brain impairment then a neuro-psychologist can do it. OTs and other healthcare professionals are no longer able to fill out the application in accordance with s.45(2)(1)(2).

**Challenges of Budgeting vs. Deductibility and Mitigation - Applicable to all levels of Med Rehab:**

Where there is a related tort action, counsel's challenge will be to deal with the deductibility of SAB payments that could have been "*received or available*" under s.267.8(1)1 of the Insurance Act while trying to balance the victim's duty to mitigate their loss by obtaining whatever med rehab assistance that might be available under the SABs. This may leave both the victim and counsel in a catch 22 position while trying not to squander the "available" benefits and yet at the same time avoid tort defence counsel's arguments that:

- a) they *failed to mitigate* their loss by benefitting from the benefits that were available but unused; and
- b) that "available" benefits were available but not used *and are therefore deductible* in response to a Future Cost of Care claim.

Although it is unlikely, it is also possible that the tort defense insurer may be approached for an *Advance Payment* to assist in the Plaintiff's medical and rehabilitation expenses once limits have run or are necessarily budgeted. At least a formal written request to the tortfeasor where the SAB limits are being budgeted may reduce Tort Defense Counsel's arguments relating to failure to mitigate damages in the tort action.

**Planning With the Health Care Team:**

Counsel will want to more carefully consult with the treatment team and advise them of some of the challenges given the limited benefits so that the benefits are best utilized. Written and personal communication with the team may avoid confusion.

Understanding the limits problems may assist healthcare providers in planning creatively so as to minimize expenses (eg. using emails as opposed to couriers or long distance calls; reducing the numbers of reports or team meetings; eliminating attendance of unnecessary team members at some team meetings etc). It might be advisable for counsel to assist the team in trying to develop some sort of reporting mechanisms which are not expensive, cost efficient and only done when absolutely necessary. These points are applicable to all three levels of medical and rehabilitation benefits including MIG, non-CAT and CAT.

**Family Help:**

Finally, the family of the victim might assist without remuneration in many of the management matters that are ongoing in treatment including filling out of forms and

paperwork either for accident benefits or for other medical services where ever possible to reduce the costs being run up by case managers or coordinators.

**Miscellaneous:**

In one paper<sup>1</sup> it was suggested that an interim benefits Motion at FSCO might be of assistance in obtaining an interim declaration of catastrophic status or interim order for payment of some costs related thereto.

If there is a tort claim it would obviously be advisable to move that as quickly as possible to Trial.

Counsel should also be in touch with the hospitals with respect to discharge planning especially in severe catastrophic injury cases. Availability of insurance may well have some impact on the hospital's plan for discharge. If the hospital is aware that there are no available benefits this may assist the victim in terms of finding alternative means for their placement if they might have obtained healthcare in a public environment.

Finally, if there is some possibility of a catastrophic designation application, it may be that the healthcare workers at the hospital or institution may assist in providing opinions relating to discharge that might be of assistance in the catastrophic designation application progress. The cost of these reports would obviously be modest as the assessment has been done in the course of OHIP paid treatment.

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Unless catastrophic insureds will only be entitled to “authorized transportation expenses” after the first 50 kms of a trip. These expenses are to be calculated in accordance with the published “Transportation Expense Guidelines”.

Non-catastrophic injuries permit in-home assessments under s.25(2).

**Treatment Plans and Emergency Funds without Prior Insurer Approval:**

There is a \$250 emergency payout for goods without a treatment and assessment plan under s.38(2)(c)(ii). In addition no treatment plan approval is required for drugs prescribed by a regulated health care professional or for the payment of an emergency expense within 5 days of the accident in question [s.38(2)(b) and (c)(i)]. Under s.38(2) all other expenses must meet the incurred expense definition and must have an approved Assessment and Treatment Plan under s.38(2) before the insurer is required to pay them.

**Rebuttal Reports:**

Another change of significance to the benefit application process is that Rebuttal reports are now no longer allowed. This will change counsel’s practice for substantial benefit applications especially for catastrophic impairment applications.

**ATTENDANT CARE - s. 14, 19, 20(2), 25.1(1)(4), 28**

**1. Minor Injury Guideline and Attendant Care**

Attendant care is not available even when optional coverage has been purchased. Moreover, even if counsel establishes that there is a pre-existing medical condition that will prevent the insured from achieving maximal recovery (thus increasing the med/rehab limits to \$50,000), it is unlikely that this will result in the Court or Arbitrator finding that the minor injury has moved into the non-catastrophic level thus entitling the insured to attendant care although it is still arguable. The definition of minor injury noted above together with “**any clinical associated sequella**” will probably suffice to keep such injury in the minor injury category preventing attendant care benefits from being ordered under s.19 due to the wording of s.14 (2) which reads “**if the impairment is not a minor injury, attendant care benefits . . .**” are available.

## **2. Non CAT Attendant Care**

Pursuant to s.19(3) a victim is entitled to up to \$3,000 per month of attendant care for the first 104 weeks after the accident. The costs of assessment, the costs of the necessary treatment plan now entitled “Assessment of Attendant Care Needs” will be deducted out of the med/rehab limits as noted above in accordance with s.18(5) as a result of the wording of s.18(5) which requires that the deduction of any such costs with respect to “any benefit or payment to or for an insured person under this Regulation...”.

As required under Regulation 403/96 the insurer must approve the need for attendant care. Under Regulation 34/10 an “*Assessment of Attendant Care Needs*” *Form 1 Application* must be filled out but only by an **occupational therapist** or **registered nurse** in accordance with s.42(1)(b).

The limit on attendant care has been cut in half from \$72,000 to \$36,000. Optional coverage can increase the limit to \$72,000 in accordance with s.25(1)4. A Rolls Royce option can be purchased under 28(1)5(ii) of up to \$1,172,000. It does not seem to increase the burn rate from \$3,000 a month to the catastrophic level of \$6,000 per month but only seems to increase the upper limit. This upper limit of attendant care is of course limited by an overall cap for non-catastrophic injuries of \$1,172,000 for both attendant care and medical/rehab combined under s.28(1)5(iii)A.

The extreme challenges of the definition of incurred expense apply to non-catastrophic injuries which issue is dealt with below under the title "Incurred Expenses". The Incurred Expenses definition will work hardship especially in the area of Attendant Care for the impecunious victim.

### **3. Catastrophic Level of Attendant Care**

Subject to the definition of incurred expense, the catastrophic impaired victim will be entitled to \$6,000 per month to a maximum of \$1 million as before.

An optional "Rolls Royce" level of attendant care may be purchased providing \$2 million of attendant care (up to a cap of \$3 million for combined medical/rehab/attendant care coverage) under s.28(1)5(ii)B.

As with non-catastrophic attendant care, the "*Assessment of Attendant Care Needs*" application must be completed by an **occupational therapist** or **registered nurse** under s.42(1)(b).

## **IMPORTANT ISSUES RELATING TO REGULATION 34/10**

### **“Incurred” Expenses s.3(7)(e): Nightmare for Impecunious Victims?**

One of the major problems that will arise for victims of motor vehicle accidents is dealing with the new definition of “incurred” expenses under s.3(7)(e). The “incurred expenses” definition applies to a number of different benefits including:

- a) caregiver benefits under s.13(2);
- b) medical benefits under s.15(1);
- c) rehab benefits under s.16(1);
- d) case manager services under s.17(1);
- e) attendant care under s.19;
- f) housekeeping and home maintenance benefits under s.23.

This definition in its renewed format will have profound implications for families attempting to obtain attendant care benefits under s.19(1) of the Regulation.

The definition that is used for incurred expenses occurs in the above s.3(7)(e) as follows:

***. . . an expense in respect of goods and services referred to in this Regulation is not incurred by an insured person unless:***

- i) the insured person has received the goods or services to which the expense relates;***
- ii) the insured person has paid the expense, has promised to pay the expense or is otherwise legally obliged to pay the expense;***

***and***

- iii) ***the person who provides the goods or services,***
  - (a) ***did so in the course of his or her regular occupation or profession, or***
  - (b) ***sustained an economic loss as a result of providing the goods or services to the insured person.***

As we are all aware family members in the past have often provided housekeeping or attendant care services and received compensation available under the SABs. This definition provides a number of stumbling blocks for an impecunious insured victim in that:

- i) they must have committed or promised to pay for an expense as a bare minimum to qualify for it. Doing so may expose him to financial risk without certainty that the insurer will pick up the expense in any reasonable period of time;
- ii) the second element of the definition provides difficulty to family provided attendant care and home keeping services in that the definition requires that such member of the family do so in the course of their “regular occupation or profession”; or has “sustained an economic loss as a result” thereof.

Obviously an unemployed family member such as someone who stays home to care for the family will not have incurred any economic loss by providing attendant care and it is impossible to predict whether or not staying home to provide attendant care will be found to be doing “....***so in the course of his or her regular occupation or profession.***”

Undoubtedly arguments will be raised that by taking on such a position especially in catastrophic cases where there is need for long term attendant care that the family member has made it his or her regular occupation or profession. It is impossible to predict how these arguments will develop but it is likely that this definition will impose a severe hardship on those who are not able to commit to obtaining goods or services because of financial circumstances and their concerns about the risk imposed by committing to such expenses without certainty the insurer will approve them.

**“Explanation of Benefit Amount” - s.50 Statements:**

Given the reduced benefits it is a positive element in the regulation that the insurer must set forth the amount spent on medical and rehab benefits and attendant care benefits every two months unless catastrophic (in which case the statements must be issued once a year). This will assist the insured in managing the reduced benefits which may be strategically important in the future. The statement will have to include the benefits paid to date, what the payments were for and the amount in the remaining limits. A benefit statement is not required to be given by the insurer under s.50(5) where the benefit payout has remained unchanged from the previous benefit statement.

***New COMBINED Assessment and Treatment Plan***

Under the former regulations there was a two step process requiring healthcare providers to:

- i) submit a request for treatment; and
- ii) prepare and submit a treatment plan for approval.

This two step process has been replaced by the treatment and assessment plan under s.38(1)2.

The assessment and treatment plan now must be ***signed by the insured*** under s.38(3).

This may create potential problems for individuals who are not able to sign or may be disabled for a while from signing a treatment plan. It is hard to know what to do if the insured may be unconscious periodically or for extended periods of time (for example, a coma). A suggestion was made in a previous conference (presented by Thomson Rogers) that counsel may in unusual circumstances want to keep blank assessment and treatment plans signed by the insured client available for times when treatment is necessary but the client may be disabled by reason of medical treatment or otherwise.

There is no provision for what to do in the event that the insured is unable or unavailable to sign the treatment plan. This is a difficult issue and one has to wonder if using previously signed forms isn't a practice ripe for problems.

### **Life Care Plans:**

The insurer is no longer responsible for paying for future care or life care plans under s.25(5)b. This will operate as a deterrent for cashing out accident benefits which may in and of itself prompt insurers to assist in the cost of future care plans if they are anxious to cash out an insured but however, the section provides a strict prohibition against paying for those using the words "shall not".

### **CAP on Assessment Fees s.25(5)(a) - Will Health Care Professionals Participate and How?:**

It is also important to note that there is a cap on all assessment examinations under s.25(5)(a) which restricts healthcare professionals to a \$2,000 cap on their fees. This absolute cap is specified in s.25(5)(a) but will create problems among healthcare professionals in doing this kind of assessment or examination/report. Undoubtedly healthcare providers will try to break the reports down into individualized sections so they may charge separately or use other strategies or, in the alternative, may opt out all together from doing this type of work.

**Interest on Overdue Benefit:**

As you may recall, the previous regulatory regime required the insured to pay 2% per month, compounded monthly, on outstanding benefits. That interest rate has been reduced to 1% “for each day the amount is overdue” from the date overdue until paid “compounded monthly”. This change under s.51(2) reduces significantly the punitive element of the interest obligation that preceded this regulation.

**Absolute Discretion of Adjusters to Deny Benefits vs. The New Deemed Benefit Rule s.3(8) and Amendments to the Unfair Practices Provisions of the Act:**

It is a matter of some concern that adjusters may deny benefits for “medical and any other reason” [s.37(4)] without the need of a s.44 I.E. for virtually all benefits provided under the Regulation. Sections 37(4) [general entitlement to deny], 38(8)[Med Rehab denial], 42(3)[Attendant Care denial] and 45(3)(b)[CAT denial] provide broad powers to insurance adjusters to deny benefits.

Under the old regime the insurer needed to follow a procedure and eventually require a s.42 examination (now s.44) upon which to base a denial. There is no longer any formal requirement to do so.

While the insured can eventually arbitrate or litigate, the extreme delays in obtaining mandatory mediation at FSCO and then waiting years for a Trial or Arbitration date will effectively preclude victims from utilizing the 1% interest on unpaid benefits relief under s.51(2) or the new Deemed Expense Reg s. 3(8). In addition it is of little practical benefit to a victim to complain under the new Unfair Practices provisions. So long as FSCO is unable to provide timely mediation or arbitration dates the maxim "*Justice delayed is justice denied*" will work against impecunious accident victims facing Insurers with deep pockets.

Section 3(8) now provides some relief to assist against an unfair insurer. It provides:

**If in a dispute..., a Court or arbitrator finds that an expense was not incurred because the insurer unreasonably withheld or delayed payment of a benefit in respect of the expense, the Court or arbitrator may, for the purpose of determining an insured person's entitlement to the benefit, deem the expense to have been incurred.**

Reg. 37/10 amends the *Unfair or Deceptive Practices* legislation by making it an unfair practice to deny benefits without reasonable cause or to misrepresent to an insured anything in order to settle a claim including misstating the conclusions of a person who conducted an examination.

**Optional Coverages s. 28:**

Generally, there are two levels of optional coverages. The first assists in giving the impression that there has been no increase in the cost of insurance in the Province of Ontario when there has been. This basic level of optional coverage allows insured drivers to effectively purchase back the limits on the preceding Regulation 403/96.

Section 28(1) 3, and 4 restore the Non CAT med rehab limit to \$100,000 and the Attendant Care benefit limit to \$72,000 as they previously were.

Under s.28(1)5 an insured can purchase Rolls Royce level benefits giving them Med Rehab benefits of \$1.1 million for Non CAT and \$2 million for CAT impairments. Rolls Royce Attendant care benefit limits then become \$1,172,000 for Non CAT and \$2 million for CAT. There is a combined ceiling of \$3 million on Med Rehab and Attendant Care. One problem for attendant care increased benefits is that there appears to be no increase in the monthly attendant care limit of \$3,000 for Non CAT and \$6,000 for CAT.

This doesn't reflect the fact that the real cost of full time attendant care is well above the amounts and attendant care rates allowed.

There are other optional coverages under s. 28 for dependant care, funeral etc. An interesting optional indexation benefit may help long term care victims. In addition, as before, one can buy optional increases in weekly IRBs up to \$600; \$800; or \$1,000 per week.

**Changes to IRB Calculations s.7(2) 1:**

Under the noted section, IRBs are to be calculated as being 70% of gross income rather than 80% of net income as they were under the previous SAB regime. This will apparently have a positive effect for insureds who don't qualify for the maximum weekly benefit of \$400 (or more if increased optional benefits have been purchased under s.28 of Reg 34/10). The 70% of gross calculation applies to employed and self employed income calculations.

There does not appear to be any amendment to the 80% of net income approach to pre-Trial loss of income awards calculations now provided for in Ontario courts. It is not known whether this will change.

**Transitional Rules: s. 2(1),(2) and 68:**

The transitional rules are about as confusing as the theory of relativity. A careful reading of s2(2) may not be helpful. Essentially, for old accidents the old benefits will apply, however, new rules will govern the claims processing.

This is a matter of concern as it appears that old policies will continue in certain instances to be in force after September 1<sup>st</sup>, 2010 (generally until the policies existing expire or are terminated). In addition, even when the old policy is still in effect, parts of it are to incorporate some of the changes in the new regulation. The position of FSCO on the issue of coverage is as follows:

“[t]he coverages and coverage limits that are available in accordance with the Old SABS under any automobile insurance policy in effect as of September 1, 2010 will remain

unchanged until the policy expires or is terminated. The only exception is if the named insured and insurer agree otherwise in writing (New SABS s. 68). The OPCF 25A (Alteration) endorsement, amended to reflect the new coverage choices available under the New SABS, will be available for this purpose.”

In a recent Bulletin sent to Insurers (FSCO 29/04/2010) FSCO espoused a simple approach that “New accidents” are ones occurring on or after September 1<sup>st</sup>, 2010. “Old accidents” are ones between November 1<sup>st</sup>, 1996 and September 1<sup>st</sup>, 2010. According to the Bulletin for accidents before Sept 1<sup>st</sup>, 2010 the old SAB benefits will apply generally. However, “references to the Minor Injury Guideline in the New SABs will be deemed to be references to the Pre-Approved Framework Guidelines under the Old SABs....”

“As of September 1, 2010, as a general rule the New SABs will govern claims processing relating to old accidents and the determination of amounts payable by insurers on account of expenses paid to establish benefit entitlements arising out of old accidents (Old SABS ss. 3(1.2), (1.5) and (1.6); New SABS s. 2(2)).”

The old adage of an exception to every rule holds true with the New SABs. “There are some exceptions to the general rule concerning the applicability of the New SABS to claims processing for old accidents and the determination of amounts payable for expenses paid to establish benefit entitlements arising out of old accidents.”

The Transitional Rules, and the exceptions thereto, are summarized in Bulletin A-04/10, a copy of which is available on the FSCO website.