NEW CHANGES TO AUTOMOBILE LEGISLATION

INTRODUCTION

When the original insurance law reforms were brought out back in 1990 and with each subsequent change, they have been led by fanfare from the government of the time that they were a simplification of the benefits available to people involved in motor vehicle accidents who sustained injuries. They more clearly defined peoples' rights and entitlements. They were for the purposes of speeding up the delivery of rehabilitation to injured people and last, but not necessarily least, were certainly intended to reduce the amount of litigation and the role of lawyers in automobile accident claims whether first party benefits with their own no-fault insurance carrier or tort claims brought against the party or parties at fault.

Despite the fanfare of the government, it seems with each change things become more complicated, the water is muddier than before and the need for lawyers is ever increasing.

One only needs to look at the changes which are to come into effect on September 1, 2010 to realize that it will again take years and lots of litigation, involving judicial and quasi judicial interpretation before anyone can truly understand what these changes mean and their true impact.

This paper is intended to give an overview of the major changes to automobile insurance claims in Ontario, their effects on individuals as well as healthcare providers, and to provide some insight into how some of these provisions may ultimately be determined, and to espouse some of the arguments that will be made by experienced lawyers in the ever continuing fight for benefits for individuals involved in motor vehicle accident claims in Ontario on and after September 1, 2010.

CHANGES IN THE RIGHT TO SUE THE AT-FAULT PERSON OR PERSONS

There were very little, if any, changes with respect to the right to bring a claim against someone else who may be totally or partly at fault for the victim injured in a motor vehicle accident. The only change, if any, of real significance is the elimination of the $15,000.00 deductible for *Family Law Act* claimants in fatal accident cases.

This certainly has to be viewed as a positive change and will enable those who survive the death of a loved one the right to some compensation. This will affect any individual who

previously had a claim that would not exceed $50,000.00 and, in particular, will have impacts on claims made by grandchildren, grandparents, siblings who, under the previous legislation, were often denied benefits on the basis that they did not exceed the $15,000.00 deductible.

With regard to the deductible which the Liberal government had promised to reduce, even prior to first being elected, they have now come out with an option to buy down an individual deductible. At the time of the writing of this paper, there had been no published rates available so we do not know what the cost to buy down the deductibles will be, but I would expect unless the cost is minimal, i.e. less than $10.00 a year, it is doubtful that anyone but the odd few motorists would pay to reduce their deductible from $30,000.00 to $20,000.00.

NO-FAULT BENEFIT CHANGES

The most significant changes in the legislation are with regard to no-fault benefits or what are often referred to as accident benefits. This is not surprising given the lobbying that occurred prior to the introduction of the legislation, and the argument by the insurance industry that no-fault benefit claims were out of control and were the greatest pressure on increasing insurance rates.

As stated in the introduction, the theoretical intention is again to simplify the system, reduce expense, and to reduce benefit entitlements to anyone who suffers an injury not classified as catastrophic. The effect will be to increase the burden on the public health system and subjectively affect outcomes and recovery from injuries.

One of the most potentially significant changes in the legislation is the introduction of a “minor injury”. Pursuant to Section 3 of the new regulation, a minor injury means a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae. The legislation also introduces the minor injury guideline which essentially is to establish the treatment framework in respect of minor injuries. At the date of the dictation of this paper, the government had not yet published their minor injury guideline.

Of concern is that a minor injury is defined to include, a sprain, meaning an injury to one or more tendons or ligaments or to one or more of each including a partial but not complete tear; a strain is defined to mean an injury to one or more muscles including a partial but not a complete tear; a subluxation means a partial but not complete dislocation of a joint; and a whiplash associated disorder means a whiplash injury that does not exhibit objective, demonstrable, definable and clinically relevant neurological signs and does not exhibit a fracture in or

dislocation of the spine. Whiplash injury means an injury that occurs to a person's neck following a sudden acceleration/deceleration force.

On the first reading of this regulation, it would appear that a person who sustains a partial tear, for example of a medial collateral ligament, would be considered to have sustained only a minor injury. It would also appear on first reading that anyone who suffers a soft tissue injury that does not involve a complete tear would fall within the classification of minor injury.

The significance and concern about the introduction of this new minor injury is that pursuant to Section 18, the monetary limit for medical and rehabilitation benefits in respect of a person who sustains an impairment that is predominantly a minor injury shall not exceed $3,500.00 for any one accident.

Pursuant to subsection (2) of Section 18, the limit of $3,500.00 does not apply to an insured person if his or her health practitioner determines and provides compelling evidence that the insured person had a pre-existing medical condition that will prevent the insured person from achieving the maximum recovery from the minor injury if the insured person is subject to the $3,500.00 limit.

This will no doubt be a very hotly contested and contentious issue. People who sustain soft tissue injuries that do not heal quickly and go on to develop chronic pain and/or chronic pain syndrome will be fighting desperately to get outside of the minor injury cap. Insurers, of course, will be attempting to keep them within that cap to prevent exposure to ongoing and much more significant medical rehabilitation expenses. Individuals who sustain these types of injuries and who retain competent lawyers, or are dealing with healthcare providers who realize that the $3,500.00 limit on treatment will not adequately cover treatment necessary for individuals with these types of injuries, will be turning to family doctors and other healthcare practitioners to provide evidence that the insured person had a pre-existing medical condition that prevents them from achieving maximal recovery. I would expect that psychologists and psychiatrists may find themselves busy indicating that individuals had some pre-existing psychological and/or emotional condition that prevents them from achieving maximal recovery, and doctors will be asked to perform radiological examinations looking for degenerative disc disease or other things that might take the injured person outside of the minor injury guideline and the restriction on benefits.

The impact on the minor injury cap could have significant impact on treatment facilities such as physiotherapy, occupational therapy, massage therapy, etc. There is also the problem of the

fact many people are without family doctors and will be looking to emergency departments and/or walk in clinics to assist them to “get out of the minor injury classification.”

It would appear that the Provincial government has taken the wording of minor injuries straight out of the legislation in Alberta. A person who has a so-called minor injury will be further restricted in having no right to make any claim for attendant care benefit, housekeeping benefit, or caregiver benefits.

Another concern is the fact that the legislation talks about “predominantly a minor injury” which may mean that it in fact you could have more than a minor injury and still be stuck with the $3500 cap.

The definition of health practitioner of course includes physicians, occupational therapists, physiotherapists, registered nurses and chiropractors, and it would appear on the face of the legislation that it is those individuals who would determine whether or not the person had a pre-existing condition that will take them outside of the minor injury classification. There does not appear to be anything in the legislation that allows for a dispute by the insurer with respect to that determination, although I suspect that there will be many disputes about whether or not there is compelling evidence that determines that issue.

The other issue may revolve around the concept of complete tear. Many doctors agree that a whiplash injury is the complete tearing of the microscopic fibrous tissues that cause pain and inflammation. Is this good enough to escape the minor injury restriction on benefits?

OTHER LIMITATIONS ON BENEFITS

As we have known for a long time, the government was going to reduce the benefits otherwise payable for non-catastrophic injuries. At one time the concern was that those benefits would be reduced to as little as $25,000.00. As we now know in regards to so-called “minor injuries” they have, in fact, been reduced all the way down to $3,500.00. On any other injuries that are not otherwise deemed to be catastrophic, the reduction has occurred in a number of areas:

1. Medical rehabilitation benefits are now reduced from $100,000.00 to $50,000.00 unless an individual purchases additional benefits coverage (again I doubt that anyone will buy those additional benefits, although the price of same is not yet known).

2. The amount of attendant care has been reduced from $72,000.00 in non-catastrophic cases to $36,000.00, so if spread over two years would be $1,500.00 a month but can still be used at $3,000.00 a month but would be consumed in one year.

3. There will no longer be any payment for housekeeping or home maintenance expenses which currently exist at $100.00 per week for two years in non-catastrophic cases unless, again, you purchase additional insurance coverage.

The government would paint this as being consumer choice but in reality is a reduction of benefits, as it is unlikely that many people will ever purchase the additional benefits partly because people do not think they will be in accidents, and secondly because people will not want to pay the additional cost. Someone who does not own an automobile but is otherwise injured in a motor vehicle accident would, of course, be restricted to the lower amounts because they would have no ability to purchase additional coverage.

The amounts for catastrophic injury remain as they were before with a right to buy additional increased insurance coverage.

DEDUCTIONS FROM BENEFITS

Another significant change in the new legislation which will have a negative impact on both injured individuals as well as healthcare providers is found in Section 18 dealing with the monetary limits re medical and rehabilitation benefits. Pursuant to subsection (5) of that section, the medical and rehabilitation benefit totals of $50,000.00 or $1,000,000.00 shall have deducted from those sums all fees and expenses for conducting assessments and examinations and preparing reports in connection with any benefit or payment to or for an insured person, other than fees in connection with an examination required by an insurer under Section 44 or a report to determine the income replacement benefit (IRB).

What this essentially means is that where an individual is injured and any healthcare provider prepares any forms and/or any reports, the cost of those forms and those reports will be deducted directly from the caps on benefits. Accident claimants may have significant monies deducted from their benefits for various reports that may be prepared by case managers, occupational therapists, physiotherapists, chiropractors, etc. and for the filling in of the various forms to claim benefits. Those that have knowledgeable counsel will likely be insisting that there be minimal if any reports prepared in order to reduce the amount of money being depleted from the medical rehabilitation benefits. I know as an example that where case managers are

going to be involved, I will certainly be demanding that they not prepare any reports for the insurer unless the insurer is prepared to pay for those independent of the med rehab benefits, and will likely only be asking for reports on an as need basis and less frequently than most providers currently prepare reports.

I am personally of the view that this may not ultimately be in the best interest of insurance companies as it may cut down significantly on the information that they will be receiving concerning the status of an injured claimant. Their only recourse may be to incur additional expense by conducting an independent assessment but only where that would be appropriate. Insurers, in negotiation, may be well prepared to simply pay the normal reports that are now produced as an expense outside of the benefits in order that they can continue to get information for their file handling.

Healthcare providers should be aware that this may have a significant impact on the amount of reports that are requested and prepared, and the fees that would otherwise be generated for those individuals and corporations.

In cases where the injured person has an experienced lawyer and where there is a tort claim, I suspect reports may be requested and used in connection with the tort claim and then claimed as a disbursement expense so that it is not deducted from the medical and rehabilitation caps. This could have an impact on the way in which reports are presently prepared in order to comply with the new rules governing expert reports in litigation.

Clearly, the concern here is that a person, particularly one who has only $50,000.00 available, may use a substantial amount of their benefits to pay for assessments and reports etc. This problem is further heightened in a situation where there is a dispute involving a benefit and the injured person needs to obtain reports and documentation to battle the insurance company and the reports that they may have obtained.

CAREGIVER AND HOUSEKEEPING BENEFITS

Housekeeping and caregiver benefits are eliminated for non-catastrophic injury cases unless the additional insurance is purchased. They continue to be available for catastrophic cases.

Again, if a person has a lawsuit against an at-fault person or persons, they may well make those claims in that action.

ATTENDANT CARE

Attendant care is another area where there has been a major change in the legislation, which certainly may have an impact on individuals who sustain both catastrophic and non-catastrophic injuries and require attendant care services.

First as previously indicated, for non-catastrophic injuries, the benefits have been reduced to $36,000.00 from $72,000.00.

Attendant care examinations will now have to be performed by nurses or occupational therapists that have been trained to use the Form 1. This is found in Section 42(1)(b) of the legislation. Interestingly, the legislation also indicates that if a guideline is issued for the purposes of application for attendant care benefits, then specific conditions, restrictions or limits with respect to the preparation of an assessment must be prepared in accordance with that guideline. Again at the time of the dictation of this paper, there was no indication that there was going to be a guideline or what that guideline might say.

Even more restrictive than the above conditions with respect to attendant care is the fact that attendant care payments will now be restricted under Section 3(7)(e). In the definitions and interpretation section of the legislation, it states “an expense in respect of goods or services referred to in this regulation is not incurred by a 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 obligated 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.”

On a strict reading of this section, it would appear that if a stay-at-home mom had a child that suffered a catastrophic brain injury and required attendant care and was going to provide those services, they would in fact not be entitled to receive the benefit. The reason they would not be entitled to receive the benefit is because they would not be a person who has sustained an economic loss as a result of providing the goods and services to the insured person. If on the other hand it was a working mother who stopped work in order to look after a child with the same injury, they would be entitled to the benefit because they could easily show an economic loss as a result of providing the goods or service, i.e. the stopping of employment and the wage that goes with it.

Again, I see this as being a fertile ground for disputes and litigation. What happens to the retired couple when one spouse requires attendant care and the other spouse provides it, again, are they going to be disentitled because they cannot show an economic loss? Also, how does an individual, such as a child, show that they have paid the expense or promise to pay the expense or is otherwise legally obligated to pay the expense when by law a minor cannot be bound to any contract?

I suspect in cases where somebody is not working before an accident and is going to provide attendant care, the argument will be made that they would have gone and sought employment but for the fact that they now need to stay home and look after the injured person to try and qualify. There is a question as to whether or not you can simply argue the fact that you are providing a service for free is in and of itself an economic loss because that time would have otherwise been spent on your own leisure activities or other pursuits other than work.

It is hoped that insurers will not try to take the position that stay-at-home moms dealing with children that have catastrophic injuries will not be entitled to receive attendant care benefits. To simply say those services can be hired from professional organizations is not feasible because the hourly rate does not change and all organizations would charge far in excess of the hourly rate payable by the insurance company and would far exceed the cap of $6,000.00 per month where care was required on even a 12/7 basis, let along a 24/7 basis.

INTEREST ON UNPAID EXPENSES

The legislation reduces the interest that is payable in circumstances where a benefit was withheld. This has been reduced from 2% per month compounded monthly to 1% per month.

FAILURE TO PAY AN EXPENSE AND NOT INCURRED

Section 3(8) regarding the incurred expenses reinforces what the case law had previously already determined, namely that if an expense was not incurred because the insurer unreasonably withheld or delayed payment of a benefit, a court or arbitrator may deem the expense to have been incurred in any event.

ASSESSMENTS

The Government has brought in a cap for the cost of assessments. That cap is $2,000.00. This applies whether the assessment and report is being done on behalf of the injured person or the

insurance company. It would appear that the $2,000.00 cap is per assessment and not per disability claim. I am interested in seeing how this limit will be enforced or policed.

Therefore, if an insurer wants to have three or four or more assessments, it appears that they will be able to have them although they will each be capped at $2,000.00. The difficulty as indicated earlier for the injured person is that they may have to incur considerable costs which will be taken from their benefits to respond to the reports created by the insurance company where a benefit is denied.

A further significant problem will be created for people attempting to be determined catastrophic at the two year mark where they may have used all of their medical and rehabilitation benefits. This means that there will be no payment forthcoming for the assessments and where there is no tort claim, they may have to rely upon their counsel to underwrite the costs of those assessments with the knowledge that if they are not deemed catastrophic those costs may never be recovered. This will certainly put additional stress and strain on people injured and attempting to get a determination of catastrophic where the med/rehab monies have been exhausted.

REBUTTAL REPORTS

They have been eliminated to the extent the insurer no longer has to pay for them.

INCOME REPLACEMENT BENEFITS

The Government has now decided to make income replacement benefits based on 70% of gross income as opposed to the previous 80% of net income. The claim is this will have little of any impact on the amounts of benefits payable and I have not yet done the calculation to see if there will be any difference.

It would appear to be much easier in doing income replacement benefit calculations to use 70% of gross income as opposed to 80% of net income. The more interesting question is whether or not the benefit will be taxable because it is not based upon net income which was of course after tax income.

There is a $2,500.00 cap on the amount that would be paid for accounting reports to determine entitlement to income replacement benefits. Again, this may be restrictive in cases where somebody is self employed and extensive calculations are necessary in order to determine the income replacement benefit.

ELECTIONS RE: INCOME REPLACEMENT CAREGIVER BENEFITS

Under the predecessor legislation, an individual could re-elect to change the benefits that they were receiving. Under the new legislation, claimants will be restricted in their ability to make any re-election in light of the fact that caregiver benefits are available only if one is considered catastrophically impaired.

CATASTROPHIC DEFINITION CHANGES

Single limb amputations will now be considered catastrophic. There is also a new guideline that is being proposed for catastrophic impairment on the basis of acquired brain injury and again at the time of the dictation of this paper that was not available.

CONCLUSION

This is as indicated an overview of the significant changes that are coming on September 1, 2010. It will be some years before we will know for certainty what all of these changes mean, how they will affect claimants and health care providers, although clearly the intention in the legislation is to once again attempt to reduce the benefits available to injured people and to reduce the cost of rehabilitation which will in turn have a negative impact on the health care providers.

It is hoped that people who become injured under the new legislation will be able to receive help from experienced lawyers who are knowledgeable about the legislation and can advocate, and where necessary litigate to ensure individuals who sustain injuries receive the maximal medical recovery and benefits to ensure their return as best as possible back to a normal life.

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This is a brief overview of the legislation, and is not intended to be relied on as legal advice.

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