

Working within the New SABs

Summary:

The new Statutory Accident Benefits (SABs) are slated to come into effect on September 1, 2010. The new SABs represent a significant cut in the benefits available to injured parties. In some cases, perhaps as high as 30 to 40% of cases, the \$100,000.00 med rehab limit will be reduced to \$3,500.00. In addition there are numerous limitations and eliminations of benefits that will significantly alter the landscape, shifting much of the funding for future medical and rehabilitation services from the Accident Benefit side of the auto claim to the tort. This will effectively leave those involved in a car accident, suffering serious injury, but with no tort claim, with a drastic reduction in available medical benefits.

The regulations, forms and Guidelines are currently in development. It is expected that there will be some additional changes although likely minor and that the draft regulations as presented will go forward by September 1, 2010. This paper will look at some of the areas of change and is not intended to be a comprehensive analysis of all proposed changes. The new SABs, like the old SABs, are an ongoing, evolving beast that will take its shape through the current development of the regulations and guidelines and later through mediation, arbitration and judicial process.

For the purpose of transitioning to the new SABs, the current auto policies that terminate after September 1, 2010 will continue, for the most part, on the same terms and conditions as contracted but will shift to the new SABs regime when renewed after that date.

SAB changes summary:

1. Reduction of medical and rehabilitation benefits from \$100,000.00 to \$50,000.00. In some cases this will be reduced to \$3,500.00 under the Minor Injury Guideline.

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2. The development of the Minor Injury Guideline to replace the Pre Authorized Framework for minor injuries. These will include WAD I and WAD II injuries but the minor injury definition also references things like partial ligament tears and “clinically associated sequelae”.
3. Assessments will be capped at \$2,000.00. This amount will be deducted from the available med/rehab benefits.
4. Rebuttal reports have been eliminated.
5. The insurer is no longer required to pay for Future Care reports. (s.25(5))
6. Catastrophic Assessments can only be “conducted” by a physician or, in the case of brain injury, a neuropsychologist. (s.45(2))
7. The definition for Catastrophic Impairment now includes a single limb amputee. (s.3(2))
8. Form 1 assessments may only be completed by a Registered Nurse or Occupational Therapist. (s.42(1))
9. Attendant Care benefits have been reduced for non CAT cases to \$36,000.00 over 2 years
10. CAT assessment under Whole Person Impairment or Marked impairment can be held before two years if brain injury involved and unlikely to cease to be catastrophic. (s.3(5))
11. The definition of medical and rehabilitation services has been modified to include other services “of a medical nature”. (s.15(1))
12. Income Replacement Benefits – the maximum remains at \$400.00 and is based on 70% of gross income. (s.7)
13. The insurer must now pay for an accounting report up to a maximum of \$2,500.00 (s.7)

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14. Caregiver benefits have been eliminated in non Catastrophic cases and replaced with an option.
15. Where the insured has selected one weekly benefit then that election cannot be changed unless the person is later deemed Catastrophically impaired. (s.35)
16. The interest rate on overdue accident benefits has been reduced from 2% to 1% compounded monthly. (s.51)
17. Housekeeping expenses have been eliminated in non CAT cases unless an option is purchased. (s.23)
18. Treatment and Assessment plan forms combined for only one approval process instead of initial approval of assessment and treatment plan later. (s.38)
19. The insurer is now provided up to 10 business days to respond to a treatment plan. (s.38)
20. Where the insured is receiving goods and services under the MIG, the insurer's denial without assessment is final and not subject to review. (s.38)
21. A definition for "incurred expense" which requires the insured to receive the goods or services, paid or promise to pay the expense and the recipient of the payment provide the goods or services as part of their regular occupation or suffered an economic loss to provide the goods or service (s.3(7)(e))

Tort changes

1. Elimination of the deductible in fatality cases.
2. Option to reduce the \$30,000.00 deductible down to \$20,000.00 and the FLA deductible from \$15,000.00 to \$10,000.00.

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Medical and Rehabilitation Benefits

Overall the SABs represent a significant reduction in medical and rehabilitation benefits for the non Catastrophically injured. The people that will be “hit” hardest will be those victims that are at fault and seriously injured. Without the benefit of a tort claim it will be very difficult to fill in the gaps in medical and rehabilitation coverage.

The majority of accident victims, subject to any options purchased, will see their accident benefits reduced from \$100,000.00 to \$50,000.00. With the introduction of the Minor Injury definition, and related Guidelines, many accident victims will find that their benefits have been reduced down to \$3,500.00 with little recourse for additional medical coverage unless they have a tort claim. Prior to the recent changes, the Insurance Bureau of Canada had indicated that the average accident benefit file cost was approximately \$40,000.00. The indications from the Financial Services Commission of Ontario are that they expect the MIG to capture 30 to 40% of accident claims.

Minor Injury Guideline (MIG)

The new SABs provide several definitions related to the minor injury:

“minor injury” means a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae

“sprain” means an injury to one or more tendons or ligaments or to one or more of each, including a partial but not a complete tear;

“strain” means an injury to one or more muscles, including a partial but not a complete tear;

“subluxation” means a partial but not a complete dislocation of a joint;

“whiplash associated disorder” means a whiplash injury that,

- (a) does not exhibit objective, demonstrable, definable and clinically relevant neurological signs,
- and

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(b) 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.

When considering what is included under the definition of minor injury, two areas of particular interest will be the reference to “clinically associated sequelae” and partial tear.

As the MIG is currently being developed, it is understood that at present psychological injury will not be included under clinically associated sequelae. This is an area of contention with respect to the current PAF framework for the treatment of soft tissue injuries. Clearly someone suffering from Post Traumatic Stress Disorder should not be considered to fall into the limited treatment provided under the MIG.

The onset of chronic pain would be considered a serious injury. However a chronic pain diagnosis will not be made until at least 6 to 9 months post accident generally. Without proper and sufficient treatment, an accident victim with soft tissue injuries could very well go on to develop a chronic pain condition. Once an injured person has received treatment under the MIG, it may be still open for the individual to come back for treatment in connection with the onset of chronic pain. The insurer will argue that treatment was provide under the MIG and that the development of chronic pain is not a new injury as a result of the automobile accident but rather a continuation and therefore no further benefits provided. For the most part however, once someone is placed in the MIG and has exhausted the available funding for treatment for those injuries, then there are no more SABs available.

This raises a very significant issue related to the adequacy of funding for treatment. Once treatment has commenced, it will only take a few courses of physiotherapy and massage and/or chiropractic care to use up the available funds and there will be nothing available to assist with a work hardening program or additional related assistance.

It will be interesting to see how injuries like a partial ligament tear (i.e. partial rotator cuff tear) will be treated. These sorts of injuries can have a devastating impact on a person’s ability to

return to work, particularly a physically demanding job environment such as in construction or manufacturing. The MIG could include a person with some scrape and contusions in the same category as those with a partial ligament tear.

Any subluxation injury that could have a serious impact on the spine will likely result in some neurological damage and as such the injured person would be removed from the MIG.

Once the \$3,500.00 is used up, if there is no diagnosis of something else, then the accident victim is done. Unfortunately, there will be people with a WAD II and have no diagnosable pre-existing condition and need additional treatment to get better but there will be no funding available under the SABs.

Those with a tort claim will have to look there for more medical coverage. The right to sue the at-fault party for future medical needs has not been eliminated. This also raises the prospect of advances to be provided by the tort insurer prior to conclusion or settlement of the action. The Plaintiff lawyer may very well have to consider that any advance will be administered and directed to treatment rather than be provided directly to the injured party. The optics of an advance for medical treatment being used to purchase, for example, a Seadoo would not be considered favourable to the plaintiff in advancing a tort claim for injuries arising from the car accident.

18. (1) The sum of the medical and rehabilitation benefits payable in respect of an insured person who sustains an impairment that is predominantly a minor injury shall not exceed \$3,500 for any one accident, less the sum of all amounts paid in respect of the insured person in accordance with the Minor Injury Guideline.

(2) Despite subsection (1), the \$3,500 limit in that subsection does not apply to an insured person 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 new SABs provide an exclusion from the MIG for injured parties. Where the injured party has a preexisting medical condition they will be able to step out of the MIG and then be eligible for at least \$50,000.00 in medical and rehabilitation benefits.

However, this exclusion will require multiple steps to be considered:

1. the health practitioner will have to render an opinion;
2. the health practitioner will have to be familiar with the goods and service provided under the MIG;
3. the health practitioner will have to provide evidence of a pre-existing condition; and
4. the health practitioner would have to indicate that the injured person will not achieve maximal recovery from the minor injury by receiving the goods or services under the MIG.

One question that immediately arises is what is considered to be compelling evidence. The Oxford dictionary definition of compelling is “arousing strong interest or attention”. One may enter the MIG and then subsequently arrange to provide the evidence of the pre-existing condition after and would be eligible for additional treatment.

From a tort lawyer’s perspective, this evidence of a pre-existing condition will have implications for the discussion around what is the impact of the evidence regarding a pre-existing condition. Will the injured party be considered a “thin skulled” plaintiff or, as the defence will argue, that the injuries were the result of a “crumbling skull” and inevitable.

The preliminary indications are that the government is expecting that 30 to 40% of injury victims will fall into the MIG. The respective FSCO committees continue to work on completing the necessary changes to implement the new SABs. This includes a Forms committee and a MIG committee. Details are currently being worked out for the MIG.

“Minor Injury Guideline” means a guideline,

- (a) that is issued by the Superintendent under subsection 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

As can be imagined, while the Guidelines have not been finalized, there has been some fight between the health professionals and the insurance bureau. The health professionals are hoping to restrict the MIG to the current PAF and make it congruent with the present regulations. However, the insurance industry is working to enlarge the definition of what is included as a Minor Injury. Others prefer a limited definition and then leave the matter to arbitration decisions to resolve.

In addition to the issue of what is included, the extent and nature of the evidence to be provided is also being worked out. For example, what will be considered “compelling evidence” of a prior medical condition. Will a family doctor’s notes and records and opinion be sufficient or will the injured person have had to have been seen by a medical specialist for the “pre-existing medical condition” to be sufficient for the purpose of escaping the MIG. The government and more particularly FSCO will be monitoring the matter closely following implementation in order to gauge how many people are escaping the MIG. With the re-implementation of HCAI better statistical evidence will presumably be available to assess. If it appears that a high number of injured victims are escaping the MIG, one can expect that there will be amendments to the Guidelines.

It is clear throughout the new SABs that the government is attempting to bring down the assessment costs that have risen considerably since the elimination of the DACs and implementation of the IME and related assessment process. One estimate was that the DAC system had a cost of approximately \$190 million and that the IME process that followed had seen assessment costs rise to just under \$400 million.

One interesting aspect of the MIG is the ability of the AB adjuster to refuse a treatment plan without the necessity of requesting an assessment.

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38 (5) An insurer may refuse to accept a treatment and assessment plan if the plan describes goods or services to be received or an assessment or examination to be conducted in respect of any period during which the insured person is entitled to receive goods or services under the Minor Injury Guideline in respect of the impairment.

(6) An insurer's refusal to accept a treatment and assessment plan under subsection (5) is final and is not subject to review.

This is certainly a departure from the usual practice of requesting an independent medical assessment to determine whether a treatment plan is reasonable and necessary. It will be interesting to see how many adjusters will actually take this step. Granted the overall funding issue is not particularly large, but there may be implications, and potential remedies for the insured, under the *Unfair or Deceptive Practices Act*.

The Act comes into play where it is shown that the insurer failed or refused to pay a claim for goods or services without reasonable cause. It will be interesting to see if adjusters utilize this section or continue with the practice of requesting an IME.

Maximizing available benefits

There are numerous examples where there is a clear waste of medical and rehabilitation of treatment funds. Clearly, the landscape has changed considerably and the available medical and rehabilitation benefits, which may be as low as \$3,500.00, and for the most part will likely be \$50,000.00 (despite the options that are available) will not be sufficient in many cases, particular for the serious injured who are not immediately deemed Catastrophically impaired.

The insured and the insurer should be giving some thoughts to how the available benefits can be maximized. This is particularly important now that the cost of examinations and assessments are considered part of the available medical and rehabilitation benefit.

The first thing to be done will be to carefully review the insured's policy to determine if an option was purchased for increased medical and rehabilitation benefits.

Where the insured has a tort claim, assessments can be obtained under the claim. Many of the assessment and examinations can be used in the tort and the AB claim. These costs will be considered a disbursement in the tort claim and are recoverable upon the conclusion or settlement of the claim. In most cases these costs are carried by the personal injury lawyer until the tort claim is settled.

With respect to medical treatment, it is important to attempt to minimize non treatment activities such as report writing and travel expenses. These latter two have seemed to increase considerable over the past few years. Report writing can be minimized and rather than monthly reports, provide more email or telephone reports and spread out the need for written reports. Travel expenses have grown considerably as a component of treatment plans over the past few years and need to be controlled and more properly assessed.

In the event that the limits have been exhausted, then some consideration would have to be given to an advance from the tort insurer where there is a viable tort claim. These funds will have to be directed to medical treatment and may very well have to be controlled by the insured's lawyer or other representative to ensure they are used for this purpose. If possible, the tort claim will have to be advanced more quickly in order to advance the claim for future medical care at the same time.

Where the insured is suffering from serious injury then the insured's representative will have to consider bringing forward the CAT assessment at the earliest opportunity. There may be an opportunity to conduct the CAT assessment prior to the 2 year mark. The insured may designated as Catastrophically impaired where the insured's injuries, both physical and psychological, bring the insured within the CAT definitions, particularly for whole person impairment or a marked impairment.

Where the insured is at hospital, and prior to discharge, any treatment or assessments that can be undertaken at the hospital will avoid having to use accident benefits. This will no doubt be somewhat difficult as hospital resources are also limited.

Assessments

As noted previously, one of the predominant issues during the 5 year FSCO review was the explosion in the cost of medical assessments. As assessments could be requested by insureds or ordered by insurers, this escalation in the costs rests with all parties involved. The government accepted that these costs had risen to an unacceptable level. The elimination of DACs and implementation of the IMEs was one prior attempt to try and reduce assessment costs in the system. The steps taken by the government under the new SABs is a very significant and harsh step towards cost reduction to the determinant of the insured.

You will see several references throughout the SABs restricting who is capable of conducting certain assessments, when assessments can be completed and the loss of certain assessments like rebuttal reports. The government is of the general view that prior to the new SABs, under the current SABs, assessments were being conducted by those that were not properly qualified to carry out such assessments. We clearly see this with respect to Form 1 assessments and Catastrophic impairment assessments.

The other issue that goes to the issue of the escalating costs is the assessors that were conducting these examinations and the frequency with which assessment reports were being requested. There is the view that certain groups involved in an insured's file would be requesting numerous reports, whether necessary or not, and forcing the insurer to respond and in many cases approving assessments, particularly due to the short time periods to respond to requests for assessments.

Clearly, many will view the idea that the cost of assessments and examinations coming out of the \$50,000.00 medical and rehabilitation benefit of the insured is a harsh step. The only exceptions to this are those examinations requested by the insurer under s.44 and reports completed by accountants for the purpose of calculating an IRB entitlement.

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s.18 (5) For the purposes of subsections (1) and (3), medical and rehabilitation benefits payable in respect of an insured person include 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 under this Regulation, other than,

- (a) fees in connection with any examination required by an insurer under section 44; and
- (b) expenses in respect of a report referred to in subsection 7 (4).

While the cumulative cost of assessments has escalated, the costs for various assessments has been quite high as well. The most prominent example is the cost of completing a Catastrophic Impairment assessment. The CAT assessment is a multi-disciplinary assessment usually including a physiatrist, psychologist and occupational therapist. At times other specialists are included such as a neurologist. Given that they are multidisciplinary, it was not unheard of to find that the total cost for these assessments were in the \$20,000.00 to \$25,000.00 range.

Further, the government has taken steps to drastically restrict the cost of assessments. Under the new SABs assessment costs are limited to \$2,000.00.

The other concern for those with CAT impairments is whether there will be funds remaining in the medical and rehabilitation limits. By the time one is able to conduct an assessment, the insured will likely have required a large number of services and the limits will have been drained. At that stage there may be insufficient or no funds to cover the cost of a multi-disciplinary CAT assessment. This will necessitate the need to monitor the state of the limits available and determine whether a CAT assessment can be conducted, based on medical advice, prior to the expiration of 2 years from the date of the accident.

Who can carry out the Assessments

Form 1

Another example of the restriction on carrying out assessments is with respect to the Form 1. Only an Occupational Therapist or Registered Nurse may complete the Form 1 – Assessment of Attendant Care Needs.

42. (1) Subject to subsection (2), an application for attendant care benefits for an insured person must be,
- (b) prepared and submitted to the insurer by an occupational therapist or a registered nurse.

CAT assessments

CAT assessments have also seen some restrictions, not in the amount to be charged for an assessment, but also in who may carry out or, in this case, “conduct” the assessment:

45 (2) The following rules apply with respect to an application under subsection (1):

1. An assessment or examination in connection with a determination of catastrophic impairment shall be conducted only by a physician.
2. Despite paragraph 1, if the impairment is only a brain impairment, the assessment or examination may be conducted by a neuropsychologist.

“physician” means a person authorized by law to practise medicine

“neuropsychologist” means a psychologist authorized by law to practise neuropsychology;

In the case of CAT assessments, the government is responding to the concern raised about people conducting CAT assessments who are not properly trained in the application of the AMA Guidelines 4th edition and then completing the OCF 19. This would then force the insurer to

respond and face a rebuttal, thereby escalating the costs not only through the assessments and but to go through the dispute resolution process of mediation and arbitration or litigation.

The key term is “conducted”. The general understanding is that a physician or neuropsychologist will be responsible for the overall conduct and coordination of the assessment, which can include various team members including the usual like a physiatrist, psychologist and/or occupational therapist. But the issue will be who can sign off on the OCF 19 and that will be restricted to the physician or neuropsychologist. This would exclude for example a chiropractor that had previously been signed off on an OCF 19 under the old SABs.

CAT assessments are, for the most part, limited to a physician. However, in the case of brain injury, then the assessment may be conducted by a neuropsychologist. There is still the issue of the Guidelines for CAT assessments to be developed. We understand that these will address appropriate training and experience. Throughout the 5 year review this is an issue that has consistently been identified by FSCO and the government as an area of concern.

Rebuttal reports

Rebuttal reports have now been eliminated. Generally rebuttal reports had little influence at the adjuster or mediation stage. In non-CAT circumstances, for the insured, it was difficult to find an assessor, particularly a specialist, to provide a report at the \$900.00 rate. Given the amount of time that would be permitted for a specialist to review a file, there would clearly be gaps affecting the quality of the work. The rate only permitted a restricted amount of time to prepare a report. The most notable gap in many of these reports is a thorough review of the insured’s medical history, particularly pre-accident and a reliance on the history taken from the insured.

However, there was no such cost restriction with respect to a CAT rebuttal report. The insurer would be spending approximately \$15,000 to \$25,000 for their assessment and then an equal amount for a rebuttal assessment. With respect to CAT reports under the new SABs, it is expected that where a multi-disciplinary assessment is conducted, the cost will be based on a cap of \$2,000.00 per assessment. The wording of the relevant section refers to any one

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assessment and it is expected that this will be interpreted on a per assessment basis for a multi-disciplinary assessment

25(5) Despite any other provision of this Regulation, an insurer shall not pay,

(a) more than \$2,000 in respect of fees for any one assessment or examination, whether conducted at the instance of the insured person or the insurer

Under the new SABs, the restriction on the cost of completing assessments will have some interesting impacts on CAT assessments. It seems to be generally accepted that the cost of reports will still exceed the \$2,000.00 cap per assessment. Where the insured has the benefit of a tort claim, then reports may be generated for the purpose of the tort claim and the AB claim. There are also options to consider protecting the account of an assessor in the tort claim. However, without the benefit of a tort claim, there will be significant funding problem for the insured to obtain the reports necessary to successfully put forward a CAT claim. If funds are available then an issue will arise with respect to the quality of the reports upon which an arbitrator will have to make a decision.

Government has laid the groundwork for one of two scenarios:

1. insureds that cannot afford the CAT assessment costs; or
2. arbitration decisions based on medical reports that are not complete or as thorough because of the funds available to complete and this will result in poor decisions. This scenario poses more of a risk for the insurer given the general view that arbitrators are more likely to side with the insured or in any event the SABs are interpreted in favour of the insured.

Cost of Future Care reports

These reports are always a difficult beast to deal with. From the plaintiff's perspective they are necessary in order to identify and quantify to some extent the future medical needs of the insured. From the insurer's perspective they are viewed as crystal ball gazing of the worst sort and scoffed at and diminished in their usefulness. At times the parties do collaborate on a report and this collaborative effort leads to greater acceptance of the recommendations since it was a joint retainer of sorts. For the most part the cost of preparing a report is not minimal. A lot of time is spent reviewing the medical documentation and preparing a comprehensive report on the future care needs of the injured party.

25(5) Despite any other provision of this Regulation, an insurer shall not pay,

(b) any amount in respect of fees for preparing a future care plan, a life care plan or a similar plan or for any assessment or examination conducted in connection with the preparation of the plan.

This will be another area where the injured party with a tort claim will have the benefit of a report prepared for the claim against the at fault party. In the case of a Catastrophically impaired party, any attempt at settlement of the Accident Benefit file could be considered negligent without the preparation of a future care report. This is particularly true where the insured is suffering under a disability and court approval would be required for any settlement. A judge would like want to see a future care report prepared when reviewing the application for approval of any settlement on behalf of the insured. In these circumstances one may attempt to negotiate an agreement with the insurer for the completion of the future care plan. However, the wording of the section will have to be given careful consideration.

Incurred expense

This represents a significant change in the administration and payment of benefits under the new SABs. Most benefits refer to "incurred" expenses.

3(7)(e) subject to subsection (8), an expense in respect of goods or 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 obligated to pay the expense, and

(iii) the person who provided 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;

3 (8) If in a dispute to which sections 279 to 283 of the Act apply, 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.

Originally, any attendant care services had to be provided by professional caregivers. This requirement was subsequently removed and the courts and arbitrations hearings have interpreted the term more liberally. A prominent example, and most likely the case that set the tone for this change in the SABs, is Belair and McMichael. Among other things, McMichael stands for the general proposition that the insurer cannot benefit from a denial of an Accident Benefit by showing that the insured did not receive the benefit during the period of denial and therefore should not be compensated for past benefits which have not been received. The arbitrator would not allow the insurer to benefit from such an argument, pointing out that the denial was one of the reasons that the insured did not have the funds necessary to acquire the medical goods and services that were deemed reasonable and necessary. The arbitrator ordered the insurer to pay the past benefits regardless of whether they were incurred or not.

It is interesting to note that section 3(8) does provide a check, somewhat, upon the insurer where the insurer unreasonably withheld or delayed payment. In that case the arbitrator may deem the expense to have been incurred.

There are a number of issues that arise from these changes. While the government addressed the issue of whether these services had to be actually received and paid for, it did not deal with the issue of the rates at which these services were to be provided at. It is well known that the rates used to determine the Attendant Care costs on a Form 1 do not in any way reflect the realities of the market place. The usual rates in the marketplace are 2x to 3x the amount allowed under the SABs.

Logistically, will the insured be required to actually incur or retain the services before the insurer will have to pay for Attendant Care. Accident victims are generally impecunious and it will be difficult to incur expenses or commit to costs without some certainty in payment.

With respect to family members, it was certainly convenient that a family member was available to provide the type of Attendant Care service needed to help an injured family member. Particularly given the low rates allowed. However, while no one would consider helping family to me an imposition (immediately) it is certainly additional work above and beyond what was provided before the car accident. By adding the requirements regarding professional services or regular occupation, or the necessity to show a lost economic opportunity, the government has unnecessarily shifted a significant burden on to the family unit. One has to ask what difference it makes to the insurer whether a family member has to quit an existing job, or lose some other economic opportunity, in order to care for the injured family member. If the Form 1 outlines the services required then the cost should be incurred and paid by the insurer, however that service is provided.

Services such as attendant care and housekeeping have traditionally been provided by family members. Now the person must suffer an economic loss in order to recover the expense. The question arises as to whether the family member has to give up a job or the prospect of employment. Further, is it any economic loss – ie. family member has part-time employment and quits to provide AC services at \$6,000.00 per month.

The issue of incurred expenses will only become an issue for housekeeping where the insured has purchased optional benefits for housekeeping or is Catastrophically impaired. It will be necessary to show that someone was retained to provide the extra housekeeping assistance

Some strategies that may be considered where the insured has a tort claim:

1. Obtain an advance payment from the tort claim. Counsel for the insured would probably have to administer payment to ensure that the funds were applied for appropriate services;
2. Negotiate a partial deferral of payment. Protect the account of the service provider until settlement is obtained;
3. Consider litigation financing. The areas of coverage are expanding but the interest rate is very high.

Definition of Catastrophic Impairment

The definition of Catastrophic Impairment has been expanded to include a single limb amputee, either an arm or leg:

- (2) For the purposes of this Regulation, a catastrophic impairment caused by an accident is,
 - (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 brings the definition into line with the evolution of the view, through CAT assessments and arbitration decisions where a single limb amputee, particularly a leg, who may be having difficulties with a prosthetic, and is considered primarily wheel chair bound, would be found to be catastrophically impaired.

Given the significant reductions in Accident Benefits, there is a concern for those suffering from serious injury and who may be Catastrophically impaired but must wait up to 2 years before the CAT assessment can be conducted. There may be an attempt to try and have the assessment, particularly under the whole person impairment of marked impairment, prior to the 2 year date. Certainly, those injured victims with a tort claim will be in a marginally better position than those

without such a claim. As funds under the medical and rehabilitation benefit are depleted over the two year period, there may be insufficient funds to conduct a CAT assessment unless there is a tort claim.

Of interest are the recent decisions dealing with a marked impairment under s.2(1.2)(g) in the old SABs and now s.3(2)(f) in the new SABs.

3(2)(f) subject to subsections (4), (5) and (6), an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

The recent arbitration decisions in *Pastore* and *Fournie* have confirmed that only one marked impairment is necessary to be considered Catastrophically impaired. The *Pastore* decision was held up on appeal to the Director Delegate and the insurer is currently seeking judicial review. It appears the issue is headed in the same direction as the ongoing debate on whether physical or psychological impairments can be combined for the purposes of determining 55% whole person impairment (for the record they are combined).

Optional benefits

The government has determined that while they are cutting accident benefits significantly on the one hand, they are still providing consumers, who can pay, access to all the coverage that they desire with the other. This is provided through the significant expansion of options available to the consumer in crafting an auto insurance policy that is "right" for the consumer's individual needs. This is similar to asking them to predict their future medical needs.

Protocols and procedures will have to be developed to ensure that an insured's policy is reviewed to know what optional benefit coverage has been included in the insurance policy. While broker liability is an area that has always been at the periphery of insurance litigation, it is very possible that we could see an increase in the number of broker claims. Brokers will have

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to adjust their current practice to deal with the large number of options that have now been added to the insurance product.

Currently, under the existing SABs, it has been reported that only 3% of consumers currently purchase optional coverage (i.e. increased income replacement benefit coverage). No doubt once cause for such a low number is the fact that consumers are not effectively, informed of the options available. The current practice will have to be altered. This may include a signoff sheet for consumers so that they can confirm they were advised of the options available they accepted or declined the options offered.

Options provided under Part VI

1. Income Replacement Benefits

- Stayed at \$400.00

Option: coverage at \$600, \$800 and \$1,000

2. Housekeeping and Home Maintenance

- No benefits provided for Minor Injury or Non Catastrophic

Option: \$100.00 per week for 2 years

Substantial inability to perform housekeeping and home maintenance normally performed

3. Attendant Care Benefits

- Not available for Minor Injury
- Maximum of \$3,000.00 per month for a total of \$36,000.00 over two years
- Assessed by an OT or RN

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- No changes for Catastrophic Impairment

Option: Increase to \$72,000 or to \$1,172,000 for non catastrophic impairment and to \$3,000,000 for catastrophic impairment

4. Optional Medical and Rehabilitation Benefit

Option: Increase to \$100,000 or \$1,100,000 for non catastrophic impairment and to \$2,000,000 for catastrophic impairment

Other medical and rehabilitation services

An area of change to note comes under the list of medical and rehabilitation services provided under the SABs. The new SABs provide an additional term to the “other” section that appears to have the intent of limiting the range of services that would otherwise be provided under the old SABs:

Old SABs

(l) other goods and services that the insured person requires, except services provided by a case manager. O. Reg. 403/96, s. 15 (5); O. Reg. 281/03, s. 4 (1).

New SABs

(h) other goods and services of a medical nature that the insured person requires, other than goods or services for which a benefit is otherwise provided in this Regulation.

One example where this change could have an impact is the provision of nanny services. In the arbitration decision of *G.B. and Pilot Insurance*, the insurer was required to pay for nanny

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services as a medical and rehabilitation expense and separate from a care giver benefit. The nanny services were necessary to allow G to attend physiotherapy and other treatments Mrs. G case where nanny services were provided over and above Caregiver benefits.

Recent Arbitration decisions of interest:

Aviva and Pastore – CATASTROPHIC IMPAIRMENT – Appeal – Only one Marked impairment in functioning required to find an insured to be Catastrophically impaired.

Fournie and Coachman Insurance – CATASTROPHIC ASSESSMENT – insured sustained injuries to left heel and ankle – required two crutches and leg brace – found to be Catastrophically Impaired under physical impairment and also under psychological – one Marked impairment sufficient – physical and psychological can be combined

Shaikh and Aviva Canada – SPECIAL AWARD – Award could be sought by insured for unreasonable delays in payments by insurer, even where insurer subsequently makes up the delayed payments and there is nothing owing at time of arbitration.