

## Avoiding Serious and Costly Error:

### Managing Bill 198 and the New Regulations from the Victim's Perspective

On December 9, 2002, "An Act to Implement Budget Measures and Other Initiatives of the Government", commonly referred to as Bill 198, received Royal Assent. As a result of Bill 198 there are several amendments to the *Insurance Act*, R.S.O. 1990, c. I.8 regarding compensation from motor vehicle accidents that occurred on or after October 1, 2003. There have been further amendments in this area, the most recent being the elimination of the Designated Assessment Centres (DACs) effective March 1, 2006. This paper discusses the impact of some of the Bill 198 amendments to the *Insurance Act* and the Statutory Accident Benefits Schedule (SABS)<sup>1</sup> has had upon insured victims.

Some of the recent changes in motor vehicle insurance include:

#### **Tort:**

- introduction of verbal threshold definitions<sup>2</sup>
- increased deductibles<sup>3</sup>
- introduction of a "vanishing" deductible for general damage awards higher than \$100,000.00 and for *Family Law Act* awards higher than \$50,000.00
- ability to recover health care expenses for non-catastrophic claims

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<sup>1</sup> As well as some of the subsequent amendments to other Regulations under the *Act*.

<sup>2</sup> O. Reg. 403/96 and O. Reg. 461/96, ss. 4.1-4.2.

<sup>3</sup> O. Reg. 461/96, s. 5.1.

### **Accident Benefits:**

- expanded definition of catastrophic impairment<sup>4</sup>
- examinations under oath
- Pre-Approved Framework (PAF) for WAD injuries<sup>5</sup>
- removal of attendant care and other benefits for WAD injuries sustained after April 1, 2004<sup>6</sup>
- tighter notice requirements<sup>7</sup>
- prohibition against settling a claim within one year from the date of the accident<sup>8</sup>
- pre-approval of section 24 assessments<sup>9</sup>
- series of changes to income replacement benefit entitlement and calculations
- removal of Designated Assessment Centres<sup>10</sup>

### **Overview**

The effect of these changes on injured accident victims depends largely on the severity of the injuries and the extent of damages sustained in a given case.

Victims who meet the now-defined threshold are able to recover health care expenses from the tortfeasor without having to prove a “catastrophic impairment”.

Victims who suffer serious injuries are not subject to any deductible if the general

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<sup>4</sup> O. Reg. 403/96, s. 2(1.1).

<sup>5</sup> O. Reg. 403/96, s. 37.1. See also Superintendent's Guideline No. 01/03, FSCO, July 2003.

<sup>6</sup> O. Reg. 403/96, s. 16(1.1).

<sup>7</sup> O. Reg. 403/96, s. 32.

<sup>8</sup> R.R.O. 1990, Reg. 664, s. 9.1(10)(b).

<sup>9</sup> O. Reg. 403/96, ss. 24, 38.

<sup>10</sup> O. Reg. 546/05.

damages are assessed at more than \$100,000.00. The accident benefits changes have not had a significant impact on seriously injured victims.

Those people who suffer less severe injuries, and for whom there has been little loss of income, could be seriously impacted by both the threshold definitions and the higher deductibles. A lawyer who is not being very careful can waste valuable time and money pursuing such claims without a financial contribution from the client. We generally follow-up with these victims six months to one year after the initial meeting, to better determine whether there is a long-term loss of income or the effect, if any, that the deductible and threshold will have on their claim.

Victims who sustain minor or moderate injuries could be greatly affected by both the tort changes and the various accident benefits changes.<sup>11</sup> Although these victims have not sustained the most serious of injuries, they have nonetheless been injured in motor vehicle accidents for which they are insured for certain losses. It is difficult to comment on the practical realities of the PAF and other types of smaller accident benefits cases since our firm does not typically handle these types of claims. It is, however, clear that the changes to the *SABS* largely favour the insurers, at the expense of legitimately injured accident victims. Those accident victims who sustain WAD I or WAD II injuries are not entitled to receive attendant care and, more significantly, are very limited in the duration of income

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<sup>11</sup> Particularly notice requirements, the PAF and changes to income replacement benefits.

replacement benefits they can receive. For all accident victims, there are tighter notice requirements following an accident with potentially serious penalties to victims who miss the statutory notice period. All victims require pre-approval before an insurer is obliged to pay for any assessment cost. The prohibition against early settlement of AB claims may be considered a beneficial change to policyholders that will protect accident victims from premature and inadequate settlement of claims. This provision also appears to curb the representation of accident victims by paralegals who often push for quick settlements.

**How has the quantum of damages changed, if at all?**

This question cannot be addressed without reference to the combined effect of the new threshold definitions and the increased deductibles. These provisions have effectively removed many smaller claims from the insurance landscape.

With the onset of Bill 198, the previous \$15,000.00 deductible from general damage awards has increased to a \$30,000.00 deductible, while *Family Law Act* claims are now subject to a \$15,000.00 deductible rather than the previous \$7,500.00. Once the higher deductible is factored in, plaintiff counsel may turn away marginal cases, where there is no loss of income, because they are just too risky. The increase of the *Family Law Act* deductible to \$15,000.00 renders the majority of *Family Law Act* claims of little or no value. The deductible is high enough that, in many cases, advancing *Family Law Act* claims will require some work with little or no opportunity for a successful result. Only in the more severe

cases, or fatality cases, will *Family Law Act* claims be pursued. As well, you need to balance the possibility that *Family Law Act* claimants, exposed to discovery, may actually do more harm than good to the injured victim's claim. Finally, one must weigh the benefit of pursuing such claims against the possibility that a *Family Law Act* claimant will be exposed to cost consequences in an otherwise risky claim (for example where liability or causation are serious issues).

Section 267.5(8) of the *Insurance Act* was amended so that general damage claims in excess of \$100,000.00 are not subject to the \$30,000.00 deductible. Similarly, *Family Law Act* claims greater than \$50,000.00 are not subject to a deductible. This change will likely have the biggest inflationary effect on the assessment of damages. Counsel will have to spend more time and energy on the general damage issues in "borderline" cases, where the vanishing deductible may come into play. Proving that general damages should be assessed at \$110,000.00 instead of \$90,000.00 may mean more to the victim financially than a loss of competitive advantage or housekeeping claim.

Negotiating tactics may well change as a result of the vanishing deductible. In borderline cases, the deductible will become another issue in the settlement negotiations. There will no longer be Rule 49 offers to settle a claim for general damages, net of the deductible, for anything between \$70,000.00 and \$100,000.00. While counsel are free to negotiate a settlement in that range, judges and juries will not be able to make an award (net of the deductible) within

that range, making a formal offer at anything other than the upper or lower end of the range unnecessary.

### **Section 24 and 42 Assessments without DACs**

Effective March 1, 2006, the DAC system will no longer exist in Ontario.<sup>12</sup> This move has been applauded by many lawyers for accident victims since “independent” DAC assessments rarely render positive reports for injured victims. The elimination of DACs is also a welcome change to insurers, but for entirely different reasons. DACs are extremely expensive and yet they are not binding on the victim in any legal sense. Despite a DAC report favouring the insurer’s interests, an insured can still pursue her claim.

In essence, the new system will substitute Insurer Examinations (I.E.s) for the DACs. An insurer may request an I.E. pursuant to s. 42 of the *SABS* to assess the reasonableness of any type of benefit that the insured person claims.<sup>13</sup> The approach will essentially mirror that taken in tort claims: the insurer and insured will each obtain their own assessments to advance their respective positions, without any “neutral” evaluation.

There will be additional burdens on the injured victim to facilitate s. 42 assessments. For instance, there is an obligation on the insured to provide the

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<sup>12</sup> O. Reg. 546/05.

<sup>13</sup> Exceptions include PAF, funeral and death benefits. O. Reg. 546/05, s. 42(1). Note that under the current system, an insurer cannot conduct a s. 42 examination for medical and rehabilitation expenses. This will change beginning March 1, 2006.

assessors with “all reasonably available information and documents that are relevant or necessary for the review of the insured person’s medical condition” within five days of receiving notice of the assessment.<sup>14</sup>

A further initiative tipping the balance in favour of insurers is the pre-claim examination.<sup>15</sup> Where an insured person is admitted to a hospital and may be entitled to medical benefits for an assistive device<sup>16</sup>, rehabilitation benefits<sup>17</sup> or attendant care benefits, but has not applied for these benefits, an I.E. doctor may, with the consent of the insured, conduct a pre-claim examination. The purpose of the examination is to determine whether the injured person is entitled to receive a benefit described above that would assist the insured person upon discharge from the hospital.

While a pre-claim examination is voluntary and there are no repercussions to the insured if she does not consent to the examination, the reality is that the vast majority of injured victims do not have counsel at this early stage. As a result, they may not know that they can (and should) refuse the examination and instead retain their own expert to assess these needs.

In the absence of a “neutral” DAC system it will become more important for the assessors to directly comment on the weaknesses of the reports generated by

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<sup>14</sup> O. Reg. 546/05, s. 42(10).

<sup>15</sup> O. Reg. 546/05, s. 32.1.

<sup>16</sup> Those assistive devices referred to in the SABS, s. 14(2)(f).

<sup>17</sup> Those rehabilitation benefits referred to in the SABS, s. 15(5)(i).

the opposing side. While section 42 assessors will address the recommendations made by the victim's treatment provider, under this new system, there is a limited opportunity for the same treatment provider to respond to the adverse findings in an I.E.<sup>18</sup> Presumably, the objective is to make it easier to resolve disputes where there are opposing positions taken in s. 24 and s. 42 assessments in the absence of a "neutral" third assessor.

Rebuttals (at least pursuant to the *SABS*) are not available where claims are made for:

- income replacement, care giver and non-earner benefits where a section 42 assessment was not previously conducted relating to the benefit claimed<sup>19</sup>
- attendant care benefits where a section 42 assessment was not previously conducted in the previous 12 months relating to attendant care benefits<sup>20</sup>
- benefits claimed under the PAF<sup>21</sup>

Given that there is no longer a third "objective" assessment it is even more important for there to be procedural fairness to allow each side to access examinations to advance their positions. Unfortunately, just the opposite has occurred. An insurer does not have to pay for a s. 24 assessment unless it was

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<sup>18</sup> O. Reg. 546/05, s. 42.1. This rebuttal may be prepared by the "original health practitioner" who submitted the treatment plan, attendant care assessment, disability certificate or application for catastrophic impairment.

<sup>19</sup> O. Reg. 546/05, s. 42.1(2).

<sup>20</sup> O. Reg. 546/05, s. 42.1(2).

<sup>21</sup> O. Reg. 546/05, s. 42.1(2).

pre-approved.<sup>22</sup> Under the new regulation, insurers will be able to obtain s. 42 examinations for all benefits as often as is “reasonably required”.<sup>23</sup> Insurers are potentially going to have more examinations, conducted more frequently, than a victim will have to advance her claim.

Seriously injured plaintiffs with fairly obvious entitlements will lose the protections that the DAC system offered. In those cases, the DACs served to protect the victims from their insurers, and also served to protect the adjusters from themselves. An adjuster who was hesitant to simply agree that a victim was entitled to a large attendant care benefit, or that a victim qualified as having a catastrophic impairment, could send the victim to a DAC knowing that the DAC would likely “do the right thing” and approve the benefit. In many of these cases, the victim’s claims were approved by the DAC, and the adjuster had some outside support should the file ever be audited. Having arguably less qualified, and less sympathetic I.E.s assess these claims creates a larger risk that the report will not help the victim, leaving the adjuster with no choice but to deny a benefit that they thought was payable. While this represents a relatively small number of claims, the results could be disastrous in the short term for a seriously injured victim who is denied a much needed benefit.

Despite the procedural unfairness to victims under the new regulation, where a claim leads to litigation, it becomes easier for an insured to discredit an I.E.

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<sup>22</sup> SABS, s. 24(1.1).

<sup>23</sup> O. Reg. 546/05, s. 42(1).

compared to a DAC since the latter had, at least, an air of neutrality.

Furthermore, I.E.s are conducted by practitioners who have seen the injured person only once compared to an ongoing treatment provider who sees the injured person over a longer period of time. With the notion of neutrality out of the equation, victims and their counsel should have an easier time limiting the weight given to reports generated by the insurer.

In an effort to balance the insurer's new rights under the expanded s. 42, there is a broadening of the behaviour that constitutes an "unfair or deceptive act or practice" on the part of the insurer.<sup>24</sup>

If an insurer does any of the following, it will be deemed to be an "unfair or deceptive act or practice":

1. Fails to pay within the time prescribed in the *SABS*;
2. Determines that a person is not entitled to a benefit, without first getting a report under s. 42;
3. Misrepresents or unfairly presents the conclusions of the s. 42 examination;
4. Arranges a s. 42 assessment with a person who is not qualified to conduct the examination;
5. Requires the victim to attend a s. 42 assessment that is not reasonably required; and
6. Fails to get written consent of the victim for a pre-claim examination.

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<sup>24</sup> O. Reg. 547/05, (Amending O. Reg. 7/00 "Unfair or Deceptive Acts or Practices").

While these violations sound very serious, and while no insurer wants to be found to be “unfair” or “deceptive”, the real consequences of such behaviour are not clear. Part XVIII of the *Insurance Act* is titled "Unfair and Deceptive Acts and Practices in the Business of Insurance", and sets out the consequences thereof. It appears that these unfair and deceptive acts have to be reported to the Superintendent of Insurance, who may then investigate, make a report, and order the insurer to cease doing any act, perform an act to remedy the situation, or even cease engaging in the business of insurance. The insurer may request a hearing if the Superintendent suggests that an order will be made against the insurer. While this may initially appear very serious, there is great scepticism that it will have any real impact in practice. Will the Superintendent investigate every allegation that an I.E. wasn't reasonably required? If so, the Superintendent will be very busy. Further, what remedy can the insured expect? The damage will have long since been done by the time the Superintendent investigates, makes a report and conducts a hearing. Unless there is some direct monetary penalty imposed that would go to the injured victim, there really are no teeth in these potential penalties from the victim's perspective.

It is hoped that injured victims and insurers will all reap the benefits of the elimination of the additional DAC expense. Less money spent on assessments should mean more money available to injured victims when it is time to settle their claims, or when it is time to consider future changes to the *SABS*. If the savings do not make their way to injured victims, but instead go solely to increase

insurance company profits, then this government's recent changes to automobile insurance should be considered nothing short of scandalous.

### **Concluding Remarks**

Bill 198 has been in place for more than two years. Despite the passage of time, we have no real case law to guide us regarding the affect that these changes will have on injured accident victims. In the face of this uncertainty, the government has continued to tinker with the accident benefits system, mostly to the detriment of these victims. Anecdotally, the most seriously injured victims will benefit from many of the changes, while all other victims have continued to see their rights eroded under Bill 198 and the subsequent regulatory changes. The system has reached the breaking point, where complexity, uncertainty and arbitrariness have replaced common sense and fairness. One can only hope that the combination of stabilized insurance premiums and huge insurance company profits will help to reverse the erosion of rights that injured accident victims have endured for many years.

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