

Life After DACs – The Plaintiff's Perspective

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The New Post DAC Regime
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I was not a fan of the Designated Assessment Centre (DAC) system. From the Plaintiff's perspective, DACs were time consuming and extremely intrusive for my clients. They rarely had a positive result for injured victims, and could create a real hurdle for the Plaintiff in both the accident benefits and tort claims. The defence would often argue that DACs were an "independent" assessment; that they were somehow above the level of the Plaintiff's own treating experts. While those involved with the system knew that, in reality, many of the same assessors providing DAC opinions one day were providing insurer examinations (IEs) and defence medical reports the next, it was difficult explaining that concept to a jury. Injured victims are better off without the DAC system.

My opinion of the DAC system was widely shared by the insurance industry as well, but for different reasons. DACs were extremely expensive and took up an inordinate proportion of every premium dollar. Since they were not binding in any legal sense, Plaintiffs would continue to pursue their claims regardless of the outcome. The system was complicated and fraught with hurdles that could trip up even the most experienced adjuster.

The consensus was that the DAC system had to go. However, agreeing that the system must be changed was much easier than agreeing upon the system that should replace it.

In March of 2004, FSCO floated the idea of a new Expert Assessor Network (EAN). This system had many of the same problems associated with the DAC system. In December of 2004, the Government circulated draft Regulations that would eliminate entirely the idea of an “independent” assessment. Under this proposal, insurers and victims would essentially resort to the tried and true “you get yours, I’ll get mine” approach that seemed to work under OMPP and continues to be the practice in all tort claims. However, given that this proposal was in the context of a first party claim, the Government made some suggestions in order to hold the insurer to a higher standard than is applicable to defence medical examinations in a tort claim. This proposal to amend the *Statutory Accident Benefits Schedule* (SABS) became Ontario Regulation 546/05 (the “new Regulation”), which came into force on March 1, 2006. The result was the elimination of the DAC system, amongst other things. This paper will briefly review the new Regulation, specifically with respect to the elimination of the DACs, and comment on how those changes will impact on the claims of injured accident victims.

From the Plaintiff’s perspective, the new Regulation has accomplished the goal of eliminating the air of neutrality attached to what were often nothing more than defence medical reports. One would have thought that the intent of the new Regulation should have also been to simplify the assessment protocol for both the insurer and insured, to level the playing field between very rich insurers and impecunious accident victims, and to decrease assessment costs so that more money could be put back into the actual treatment of accident victims. With the exception of possibly lowering assessment costs for insurers, the new Regulation accomplishes none of these goals.

The Regulation

The new Regulation eliminates the DACs (and all “neutral” assessments). Instead, insurers will continue to adjust the claim based on s. 42 examinations, and the injured victims will continue to support their claims based on disability certificates, s. 24 examinations, and rebuttal examinations (the new s. 42.1). This required some drastic changes to the *SABS*.

Under the new Regulation, insurers can demand Disability Certificates for “specified benefits” (any of the weekly benefits and the housekeeping benefit) not only with the initial application, but whenever they want to determine the insured person’s continuing entitlement to a benefit. The timelines to provide the Certificate are short, and entirely unrealistic in today’s age of lengthy waiting times just to get in to see a physician, let alone to get a form prepared and submitted. The failure to submit a Certificate within these short timelines results in a denial of the benefit claimed, unless a “reasonable excuse” can be provided. Good counsel should add the “reasonable excuse” letters to their precedents, so that as soon as the insurer requests a Certificate, they can be put on notice that the insured may not be able to provide it within the short timeframe permitted by the *SABS*. The insured must then make reasonable efforts to get the Certificate as quickly as possible, and then send it to the insurer with a letter confirming the “reasonable excuse”.

While the claims for “specified benefits” are commenced or continued with a Disability Certificate, the claim for medical and rehabilitation benefits begins with the Treatment Plan. The provision that permitted unknowing insured persons to submit applications for expenses after the expenses were incurred has been eliminated (with the exception of “emergency” expenses within 5 days of the accident), so insureds must be very careful to submit Treatment Plans before any expense is incurred.

Even when an insured submits a Disability Certificate or a Treatment Plan as required by the *SABS*, the insurer has the unfettered right to have the claim assessed under s. 42, as often as is "reasonably necessary". Previously, insurers could not conduct s. 42 examinations for medical and rehabilitation expenses (unless Mediation had first been requested). With the elimination of DACs, insurers now need to use s. 42 to assess all benefits and expenses. If the insurer wants to deny any benefit, it must request a medical assessment to support the denial.

If the insured does not like the results of the I.E., they can request a rebuttal assessment or examination from the person who completed the Treatment Plan or Disability Certificate, at the insurer’s expense. If the insurer used someone from a different health profession or specialty for the s. 42 examination, the insured can choose to have this rebuttal prepared by a different specialist as well.

This system of submission, s. 42 examination and rebuttal applies in a similar manner to claims for attendant care benefits.

Anyone who has attempted to read the new Regulation will realize that the above description is very, perhaps overly, simplified. Historically, simple and *SABS* have only the “s” in common. This new Regulation carries on the great tradition of consumer protection legislation that is impossible for any consumer, let alone many experienced insurance law practitioners, to understand. The devil is in the details – short timelines, countless exceptions and preconditions, unbalanced limitations between the rights of insurer and insureds, and rules that constantly change depending upon the stage that one is at in the claim. There is no substitute for reading, analyzing, and then re-reading the new Regulation in order to appreciate all of the changes and procedures. Every lawyer practicing in this area must take the time to do so, likely several times, before any steps should be taken on behalf of an injured accident victim.

Pros for the Plaintiff

Anything that eliminates the misconception of “neutral” assessments is good for injured victims. The overwhelming majority of DACs did not come back in favour of the victim, and many of those that did were of limited value in the long run. Under the new Regulation, it is clear that assessments are either being done for the victim or for the insurer. There is no middle ground. This will make it easier for victims to discredit the IE doctors, as there is no suggestion that they are neutral. Generally, victims will have experts on their side who have seen them many times, over the course of a long period of time. On the other hand, IE doctors are at a significant disadvantage only seeing the victim once, for a relatively short period of time.

The timelines for s. 42 notices can be very short, and some of the other provisions complicate matters for the insurers. There are plenty of areas where an adjuster can make a mistake that will benefit of the victim. For example, a benefit cannot be refused until the insurer has received a s. 42 report. If the adjuster doesn't follow all of the rules in setting up the IE, or providing the report to the victim, the insurer will have to continue paying benefits for much longer than they might have otherwise. Of course, counsel for accident victims will have to know the details of the system better than the insurance adjusters handling the claims in order to take advantage of these errors.

Hopefully, the system will result in a decrease in assessment costs. While this may seem like more of a benefit to the insurers, the victims should also benefit in the long run. Less money spent on assessments should mean more money available to the injured victim when it comes time to settle the claim. More importantly, less money spent on assessments, and lower overall costs to insurers, should make it easier for victims' groups to argue for money to be put back in the system to benefit those truly deserving, like a reduction in the ridiculous \$30,000 tort pain and suffering deductible.

Casualty insurers have been reporting record profits recently. Insurers have not even started to realize the tremendous savings on tort claims resulting from the Bill 198 changes that came into effect in late 2003. Once the lowered assessment costs hit the bottom line, the insurers will be hard pressed to argue against measures that put some

money back into the system for injured accident victims (although they will undoubtedly try).

Cons for the Plaintiff

While it was the rare DAC that came out in favour of the injured victim, it is even more rare for an IE to help the victim. Many IE assessors perceive that their job is to help insurers deny claims, or at the very least contain costs. The assumed (if not actual) bias of the IE assessors may quickly help to sour the relationship between insurer and injured victim.

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”. 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 IEs assess these same claims creates a larger risk that the report will not help the victim. While this represents a relatively small number of claims, the results could be disastrous for a seriously injured victim who is denied a much needed benefit.

A better balance needs to be struck between s. 42 and s. 24 examinations. Before the last round of changes were made to s. 24, victims had an almost unfettered access to assessors who could help them support their claims. While this may have created an opportunity for abuse, the pre-approval system that has since been put in place has put very significant limitations on s. 24. However, these restrictions were put in place at the same time that s. 42 was amended to restrict insurers from requesting IEs for medical and rehabilitation claims. The balance was far from equal (victims clearly got the raw end of that deal), but the new Regulation creates even more of an imbalance. Under the new Regulation, insurers are permitted to demand s. 42 examinations for all benefits (as often as is “reasonably necessary”), while the victim still must request pre-approval for almost all s. 24 examinations. The insurer can even demand a s. 42 examination of a s. 24 request for pre-approval! In fairness, new provisions have been put in place that permit an insured to respond to a s. 42 examination, at the insurer’s expense, as long as the cost is not more than \$775, or \$900 for a specialist. Finding a qualified specialist who will do an assessment for \$900 will be very difficult. Needless to say, expanded rights to s. 42 examinations in the face of a very restrictive s. 24 creates even more of an imbalance than has existed for years. Given the relative financial position of the insurer and the victim, a better balance must be struck to attempt to level the playing field.

Unfair and Deceptive Practices

In an effort to balance the insurer’s rights under the broadened s. 42, a number of “strict” guidelines have been put in place to ensure that the insurer does not abuse these rights. The new Regulation includes an amendment to Ontario Regulation 7/00 (*Unfair or*

Deceptive Acts or Practices) to make it clear that certain acts are not permitted. 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 certain expenses 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 when required to do so;
3. Misrepresents or unfairly presents the findings or 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;
6. Fails to get written consent of the victim for a pre-claim examination.

While these violations sound very serious, and while no insurer wants to be found to be “unfair” or “deceptive”, the consequences of such behaviour are not clear. Part XVIII of the *Insurance Act* deals with such acts, and sets out the consequences thereof. It appears that these unfair and deceptive acts have to be reported to the Superintendent of Insurance, who then may 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 any order will be made against the insurer. While this may initially appear very serious, there is great skepticism that it will work in practice. Will the Superintendent investigate every

allegation that an IE wasn't reasonably required? If so, this will be one very busy Superintendent. 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.

In conclusion, the new Regulation is no friend of the accident victim. While the elimination of the DACs are an overall improvement in the system, the other amendments that accompanied this positive change have made the system even more complex and weighted against insureds. When the OMPP *SABS* was introduced in 1990, it had 29 sections. We are now up to 83 sections in the current *SABS*, many of which have been revised several times since 1996. Every lawyer must be familiar with all of the timelines and requirements in the new Regulation in order to best serve their clients. The timelines are too short to research each new issue when it arises. Precedent letters should be prepared to doctors, rehabilitation clinics, etc. making them aware of the short timelines so that information can be requested (and then provided) in a timely fashion. Precedent letters should be prepared to insurers to set up the "reasonable excuse" when the insured is inevitably unable to comply with unreasonably short timelines. One can only hope that the next set of changes to the *SABS* will focus on simplifying the system for all involved.

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