

ACCIDENT BENEFIT CHANGES

Overview of the Statutory Accident Benefits Schedule—Ontario Regulation 34/10—effective September 1, 2010

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by Darcy Merkur & Leonard Kunka of Thomson, Rogers

INTRODUCTION

A new Statutory Accident Benefit Schedule effective September 1, 2010 has been introduced in Ontario. The new Regulation (referred to herein as the “new SABS”) is Ontario Regulation 34/10.

The changes are being introduced by way of a completely new Regulation, rather than by way of an amendment to the current Statutory Accident Benefits Schedule (Ont. Regulation 403/96, referred to herein as the “old SABS”).

The new SABS serve to restrict and reduce the accident benefits available in serious but non-catastrophic cases. Generally speaking, the new SABS will have a negative impact on motor vehicle accident victims in Ontario.

While the new SABS has been designed to allow consumers to purchase optional benefits to either restore the reduced accident benefits or to enhance those benefits further, it must be remembered that optional benefits exist under the current SABS, and only 3% (approximately) of insured persons purchase the currently available optional coverage. With this background, it is unrealistic to think that motorists will suddenly understand the need to purchase optional coverage to properly protect themselves in the event of a motor vehicle accident. Quite simply, most people opt for the cheapest insurance they can purchase. Many feel their insurance premiums are currently far too expensive. Generally motorists will not purchase optional coverage as it would increase their insurance premiums.

For optional benefits to be meaningful, the public must be educated on the limitations of the new standard automobile insurance policy. An education program is required to ensure that consumers recognize how the current benefits have been reduced and the value in purchasing some of the available optional benefits. The government has taken on the goal of educating the public on optional benefits, but in doing so, the government must ensure that the public education program includes requirements that brokers properly explain the effect of the optional coverages to motorists when they are renewing their policies. There also needs to be some mechanism to verify that insured persons have actually considered the optional coverages, and made an educated decision to either purchase the optional coverages or reject them.

This paper will begin by reviewing all of the procedural changes in the new SABS and will conclude with a summary of the standard accident benefits available under the new SABS.

While many of the changes have been addressed in this paper, this paper is intended to focus on the more significant changes. Also, because the new SABS have only been available since March 3, 2010, it is anticipated that additional information will soon be made available through the Financial Services Commission of Ontario, including the introduction of Guidelines such as the Minor Injury Guideline, and this further information may impact on some of the analysis in this paper (look for updates at www.thomsonrogers.com).

1) THE NEW SABS PROCESS—OVERVIEW

The new SABS process will force insured persons to be more conscious about the benefits they claim, including how quickly they are exhausting the available benefits.

Because claimants will now be paying assessment costs out of their limited medical and rehabilitation benefits, claimants will be forced to conduct a cost-benefit type of analysis before proceeding with comprehensive assessments and/or treatment, even if such assessments and/or treatment seem reasonable and necessary.

In addition, a particularly troubling change which permeates the new SABS is the new definition of the term “incurred”. Because virtually every benefit available under the SABS refers to expenses which must be “incurred” by the insured person, the new SABS tries to restrict payment of benefits to situations where the claimant has paid for the service, and the service is being provided by a person who is doing so as part of their regular occupation or profession. Where the person providing the service is a family member, that person must suffer an economic loss by virtue of providing the service in order for the insured person to recover the expense. One example of where this will create injustice is the common situation where a non-employed family member provides necessary attendant care to an injured family member. By virtue of the change in definition of “incurred”, the injured victim will face a tremendous hurdle in recovering compensation for the attendant care provided by their family member.

Below is a detailed summary and analysis of the major new SABS process changes.

a) REDUCTION IN BENEFITS:

The new SABS significantly reduces the benefits available to motor vehicle accident victims, primarily those suffering from non-catastrophic impairments. In section 2 of this paper there is a comprehensive review of the benefits available to those suffering from minor injuries, non-catastrophic injuries, and catastrophic injuries, and a chart will be provided which will graphically summarize the notable changes and available benefits.

Below is a point form summary of the significant accident benefit reductions:

- i) Medical and Rehabilitation Benefits reduced to \$50,000 from \$100,000 for non-catastrophic injuries [s. 18(3)(a)]—and note assessment and examinations costs now come out of medical and rehabilitation limits in all cases—as discussed below.
- ii) Attendant Care Benefits reduced to \$36,000 (from \$72,000) for non-catastrophic injuries [s. 19(3)2]—and note the implications of the word “incurred” discussed below.
- iii) Housekeeping Benefit (\$100 per week) eliminated for non-catastrophic injuries and replaced with optional benefit [s. 23].
- iv) Caregiver Benefit (\$250 per week plus \$50 per week for each additional person in need of care) eliminated for non-catastrophic injuries and replaced with optional benefit [s.13(1)].

b) ASSESSMENT AND TREATMENT ISSUES:

i. Assessment Costs Paid out of Medical and Rehabilitation Limits

The new SABS eliminate “assessment costs” as a separate category of accident benefits.

Previously, accident victims had access to additional funding, over and above their medical and rehabilitation limits, to pay for necessary assessments to determine their entitlement to benefits, or to determine medical or rehabilitation services they might require.

The new SABS specify that all fees and expenses for conducting assessments, examinations and preparing reports are to be paid out of the claimant’s medical and rehabilitation limits.

Section 18(5) of the new SABS states:

18. (5) For the purposes of subsections (1) and (3) {the applicable med/rehab limits}, 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 {insurer examinations}; and
- (b) expenses in respect of a report referred to in subsection 7 (4) {accounting reports to quantify income replacement benefits}.

As indicated above, medical and rehabilitation limits are not reduced by the cost of insurer examinations or the cost of an accounting report to help quantify income replacement benefits.

In cases where the applicable medical and rehabilitation limits are likely inadequate, claimants may, unfortunately, have to weigh the utility of the requested assessment with the need for treatment.

ii. Cap on Costs of Assessments/Examinations

Under the new SABS, assessment or examination costs, including insurer examination costs, are limited to \$2,000.

Section 25(5)(a) states:

- 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.

This \$2,000 maximum fee per assessment or examination applies regardless of whether the injuries are catastrophic or non-catastrophic. It also applies to insurer examinations.

Interestingly though, a potential gap exists between the wording of s. 18(5) and s. 25(5)(a). While s.18(5) indicates that “all fees and expenses for conducting assessments and examinations and preparing reports” come out of the claimant’s medical and rehabilitation limits, the \$2,000 cap specified in section 25(5)(a) does not mention the cost of “preparing reports”. Accordingly, it is arguable that the cost of “preparing reports” is not subject to the \$2,000 assessment and examination cap.

In addition, since the cost of insurer examinations are not deducted from a claimant’s medical and rehabilitation limits, the door may be open for insurers to pay unlimited amounts to doctors performing insurer examinations, for “preparing reports”, over and above the \$2,000 assessment and examination cap.

Representatives of FSCO have advised us of their view that the \$2,000 cap was intended to include the cost of “preparing reports”.

iii. Form 1 to be Completed by OT or Registered Nurse

Under the new SABS, only an Occupational Therapist (OT) or Registered Nurse (RN) may complete an Assessment of Attendant Care Needs (Form 1). Previously, other health practitioners would occasionally complete the Form 1 to expedite the payment of benefits in certain obvious cases, for example, where 24 hour supervision at an amount over the applicable monthly cap was clearly required.

Now subsection 42(1) restricts the completion of the Form 1 to the OT or RN. It states:

42. (1) Subject to subsection (2), an application for attendant care benefits for an insured person must be,

- (a) in the form of and contain the information required to be provided in the version of the document entitled “Assessment of Attendant Care Needs” that is approved by the Superintendent for use in connection with the claim; and
- (b) prepared and submitted to the insurer by an occupational therapist or a registered nurse.

(2) If a Guideline issued for the purpose of this section specifies conditions, restrictions or limits with respect to the preparation of an assessment of attendant care needs, the assessment of attendant care needs must be prepared in accordance with the Guideline.

Subsection 42(2) refers to a Guideline for the purpose of clarifying the parameters of an attendant care assessment. There is no such Guideline in circulation at this time. Previous discussions regarding changes to the SABS had suggested a further requirement that the health care provider completing the Form 1 be “trained on its completion” and it is believed that the reference to a Guideline in section 42(2) may be aimed at incorporating this requirement.

iv. The New Treatment and Assessment Plan

The new SABS eliminate the current two part process which requires health care providers to submit a request for assessment (which can be approved or denied by an insurer), followed by the preparation of a treatment plan (which also can be approved or denied by the insurer). Under the new SABS, there will be a single form called a “Treatment and Assessment Plan” which will have to be submitted to the insurer for approval, although this new form is expected to be similar to the current SABS forms.

The treatment and assessment plan process is set out in section 38.

Subsections 38(1) and 38(2), when read together, make it clear that approval of assessments or examinations are subject to approval of a “treatment and assessment plan”.

Subsections 38(1) and 38(2) state:

38. (1) This section applies to,

- (a) medical and rehabilitation benefits other than benefits payable in accordance with the Minor Injury Guideline; and
- (b) all applications for approval of assessments or examinations.

(2) An insurer is not liable to pay an expense in respect of a medical or rehabilitation benefit or an assessment or examination that was incurred before the insured person submits a treatment and assessment plan that satisfies the requirements of subsection (3) unless,

- (a) the insurer gives the insured person a notice under subsection 39 (1) stating that the insurer will pay the expense without a treatment and assessment plan;
- (b) the expense is for an ambulance or other goods or services provided on an emergency basis not more than five business days after the accident to which the application relates; or
- (c) the expense is reasonable and necessary as a result of the impairment sustained by the insured person for,
 - (i) drugs prescribed by a regulated health professional, or
 - (ii) goods with a cost of \$250 or less per item.

As indicated above, certain items, such as prescription drugs or goods with a cost of \$250 or less are to be paid by the insurer without requiring the insured to seek prior approval from the insurer by way of a treatment and assessment plan. While some health care practitioners may view this section as favourable to the insured (because it permits certain medical items to be obtained for the insured without requiring prior approval from the insurer), this section may not be as favourable as hoped since the section still refers to the expense being “reasonable and necessary”. In other words, the insurer can still deny payment for such expenses by claiming that they were not reasonable or necessary for the insured’s condition. This argument will be difficult to make in the case of drugs prescribed by a treating physician, but easier to make in other situations.

Subsection 38(3) also makes it mandatory that a treatment and assessment plan be signed by the insured person unless waived by the insurer. It states:

38. (3) A treatment and assessment plan must,

- (a) be signed by the insured person unless the insurer waives that requirement;
- (b) be completed and signed by a regulated health professional; and
- (c) include a statement by a health practitioner approving the treatment and assessment plan and stating that he or she is of the opinion that the goods, services, assessments and examinations described in the treatment and assessment plan and their proposed costs are reasonable and necessary for the insured person’s treatment or rehabilitation and,
 - (i) stating, if the treatment and assessment plan is in respect of an accident that occurred on or after September 1, 2010,
 - (A) that the insured person’s impairment is not predominantly a minor injury, or
 - (B) that the insured person’s impairment is predominantly a minor injury but, based on compelling evidence provided by the health practitioner, the insured person does not

come within the Minor Injury Guideline because 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, or

- (ii) stating, if the treatment and assessment plan is in respect of an accident that occurred before September 1, 2010,
 - (A) that the expenses contemplated by the treatment and assessment plan are reasonable and necessary for the insured person's treatment or rehabilitation, and
 - (B) that the impairment sustained by the insured person does not come within a *Pre-approved Framework Guideline* referred to in the Old Regulation.

Accordingly, to facilitate prompt submission of treatment and assessment plans, it would be prudent for personal injury lawyers to have clients sign blank treatment and assessment plans at the outset, and later verify the client's instructions to proceed to submit any completed plans.

With respect to the new, all-in-one, assessment and treatment plan approach, it is unclear how the government expects a health practitioner to complete a treatment and assessment plan without first completing an assessment. Regarding the costs associated with the completion of the treatment and assessment plan, paragraph 3 of subsection 25(1) addresses the cost of "reviewing and approving" such plans, by stating:

25. (1) The insurer shall pay the following expenses incurred by or on behalf of an insured person:
- 3. Reasonable fees charged by a health practitioner for reviewing and approving a treatment and assessment plan under section 38, including any assessment or examination necessary for that purpose, if any one or more of the goods, services, assessments or examinations described in the treatment and assessment plan have been:
 - i. approved by the insurer,
 - ii. deemed by this Regulation to be payable by the insurer, or
 - iii. determined to be payable by the insurer on the resolution of a dispute in accordance with sections 279 to 283 of the Act.

Realistically, health practitioners are likely going to continue the logical course of submitting what is akin to a request to assess on the appropriate "assessment and treatment plan" form and then proceed to submit a second "assessment and treatment plan", akin to what traditionally was a treatment plan, after completing the assessment.

v. Deadline to Respond to Treatment and Assessment Plans

Previously, insurers had only 3 business days to respond to an application for approval of an assessment or examination (s. 38.2(6)(c) of the old SABS). However in order to correspond to the new change requiring the submission of a "treatment and assessment plan", that onerous deadline has been increased.

Insurers now have 10 business days to respond to treatment and assessment plans by virtue of section 38(8), which states:

(8) Within 10 business days after it receives the treatment and assessment plan, the insurer shall give the insured person a notice that identifies the goods, services, assessments and examinations described in the treatment and assessment plan that the insurer agrees to pay for, any the insurer does not agree to pay for and the medical and any other reasons why the insurer considers any goods, services, assessments and examinations, or the proposed costs of them, not to be reasonable or necessary.

vi. Elimination of Rebuttal Reports

The new SABS has eliminated the opportunity for health practitioners to be paid for completing rebuttal reports.

Presumably, the rebuttal process had little impact on changing anyone's opinion and so the entire rebuttal process has been scrapped in the new SABS.

However, without the right to rebut insurer examination reports, health practitioners will be unable to respond to contrary positions or errors contained in insurer examination reports. In such cases, health practitioners should dialogue with the claimant's personal injury lawyer to discuss other potential means of effectively responding to controversial insurer examination reports.

The elimination of the right to rebut an insurer's examination could have drastic implications for catastrophic impairment applications. Previously, while caps were placed on the cost of most rebuttal reports, a cap was not placed on the cost of catastrophic application rebuttal reports.

As a result of the elimination of catastrophic application rebuttal reports, many claimants will now face challenges in trying to effectively advance a catastrophic impairment application or dispute. This underscores the need to have experienced counsel involved on behalf of the claimant who can propose solutions to these constraints.

vii. Insurer Not Responsible for Future Care Plan/Life Care Plan Costs

Under the new SABS, the mandatory wording indicates that insurers are not required to pay for any future care plan, life care plan or similar plan.

Section 25(5)(b) states:

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.

Without a future care plan, it will be difficult to properly engage the accident benefit insurer in settlement discussions regarding a lump sum payout of the

insured's future entitlement to accident benefits. Similarly it will be difficult to assist injured parties in designing an appropriate structured settlement in the case of a lump sum accident benefit settlement.

Insurers have always argued that the costs of a future care plan should be borne by the tort insurer, yet there are numerous cases where seriously injured people have no tort claim, and only have a claim for accident benefits. In addition, even in cases where there is a tort claim, because the tort insurer is entitled to a credit for the value of the future accident benefits payable (by way of an assignment of benefits), it is still important to be able to properly calculate the accident benefit value of the required future medical, rehabilitation, attendant care, housekeeping and home maintenance expenses the insurer will require.

It is unclear how this prohibition on the recovery of the cost of future care plans will impact accident benefit settlements. It is noted that the Courts have acknowledged an accident benefits insurer's good faith obligation to engage in settlement discussions with a claimant where the claimant's ongoing entitlement to the benefit is clear. For example, in the case of *Adler v. State Farm*, (2009) CanLII 25306, (Ont. S.C.) Madam Justice Spies of the Ontario Superior Court of Justice stated, at paragraph 30:

"...once it was known that the Applicant's injuries were catastrophic and that he required care for the rest of his life, the insurer had a good faith obligation to negotiate a reasonable lump sum settlement instead of simply letting the payments run their course."

viii. Timeline for Insurer Examinations Removed

Under the old SABS, the insurer had to conduct an insurer examination in order to support the denial of a request. To ensure that the insurer did not delay in obtaining an opinion regarding whether the benefit claimed was reasonable and necessary, strict deadlines were put in place to ensure that the insurer examination was promptly scheduled and conducted and that the report generated from the insurer examination was made available in a timely manner.

Under the new SABS, the timeline for conducting an insurer examination and the deadline for the insurer examiner to generate a report have been removed.

Presumably these deadlines have been removed since the requirement for an insurer examination is now discretionary.

We note that an insurer must still provide an insurer examination report to the claimant within 10 business days of the insurer receiving it, in accordance with section 45(5) of the new SABS.

Realistically, this change will result in claimants filing for mediation in the face of a denial without waiting for the completion of the insurer examination and without waiting to receive the insurer examination report.

c) INCURRED EXPENSES:

Because of the significance of this definition change, a separate paper has been prepared by Thomson, Rogers addressing the issue in more detail. Reference to that paper is highly recommended.

The new definition of “incurred” is a significant and horrendous change in the new SABS from the perspective of the insured person.

The definition of “incurred” now requires three separate and distinct components, which, in many cases, will create a significant hardship for the insured person to meet.

The word “incurred” is used in almost every section to qualify for benefits under the SABS (caregiver benefits [s.13(2)], medical benefits [s.15(1)], rehabilitation benefits [s. 16(1)], case manager services [s.17(1)], attendant care benefits [s.19(1)], and housekeeping and home maintenance benefits [s.23]). Consequently, this single definition change will have a reverberating impact on many insured person’s entitlement to benefits.

The controversial definition of “incurred” is found in section 3(7)(e) which states:

3. (7)(e) subject to subsection (8) {set out below}, 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;

The first requirement usually poses no difficulty. Similarly, even where the insured has not yet paid for a service which has been received, it is quite easy to argue that there is a “promise to pay” or “legal obligation to pay” the expense, (although when dealing with services provided by friends and family, this requirement may pose some philosophical barriers regarding charging loved ones for services).

It is the third requirement which is most contentious. Where the service is being provided by a professional service provider, meeting the third criteria is no

problem. However, in many serious cases, services such as attendant care are often provided by family members. This is so for a number of reasons:

- i) family members feel an obligation to care for their injured family members and often do not want strangers to be providing sensitive personal services to their injured family member;
- ii) the rates for various professional services provided for in the SABS do not reflect the “real market rates” for purchasing these services; and,
- iii) The limits for the various categories of accident benefits under the SABS are often not sufficient to cover the amount of services a person truly requires, especially when dealing with a lifetime of need.

Consequently, the families of seriously injured people simply cannot afford to hire professional caregivers or service providers at real market rates to care for and treat their injured family member for the duration of their injury. The effect is that one or more family members often take on the role of providing care to the injured party. Often these family members are the people who are not working, or are retired and therefore can more easily assume the burden of caring for their injured family member. A typical example is the homemaker who assumes the burden of caring for their seriously injured child. Using the strict reading of the new definition of “incurred”, this family member would not receive compensation for the attendant care services they provide to their injured family member because they did not sustain an “economic loss” in providing the services to the insured person.

This is an absolutely punitive result for catastrophically injured victims, because, as previously noted, the families of catastrophically injured victims cannot afford to hire professional service providers and caregivers to provide care and treatment to a catastrophically injured person for the duration of their injury, especially at the mandated SABS rates. The family will exhaust the available accident benefits and have no money left to take care of their injured family member much sooner if they are forced to hire professional caregivers and service providers at real market rates in order to have the accident benefits insurer pay for those services.

Subsection 3(8) provides a narrow potential relief clause for the harsh implications of the definition of “incurred” expenses in certain contentious situations. This section provides Judges and Arbitrators with the power to deem an expense an “incurred” expense, where the insurer unreasonably delayed or withheld payment of a benefit that would otherwise have been incurred.

Subsection 3(8) states:

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.

Thankfully, where an injured person has a viable tort case, they will, in their tort claim, be able to advance the value of the attendant care services provided by persons like family members at market rates and without regard to the new SABS definition of "incurred".

d) WEEKLY BENEFITS:

i. Weekly Benefit Election Now Irreversible

If an insured qualifies for more than one weekly benefit, namely an income replacement benefit, a non-earner benefit or a caregiver benefit, the insurer must elect which benefit they wish to receive and the election cannot be changed. The insured will have 30 days to make the election after receiving notice from the insurer of the right to make such an election.

Section 35 states:

35. (1) If an application indicates that the applicant may qualify for two or more of the income replacement benefit, the non-earner benefit and the caregiver benefit under Part II, the insurer shall, within 10 business days after receiving the application, give a notice to the applicant advising the applicant that he or she must elect, within 30 days after receiving the notice, the benefit he or she wishes to receive.

(2) If an applicant is determined to have sustained a catastrophic impairment as a result of an accident, the insurer shall, within 10 business days of the date of the determination, give a notice to the applicant advising the applicant that, despite any election previously made under subsection (1), he or she may elect, within 30 days after receiving the notice, to receive a caregiver benefit if the applicant would otherwise qualify for a caregiver benefit.

(3) The applicant's election under subsection (1) is final and can be subsequently changed only if permitted under subsection (2).

Since caregiver benefits are no longer available in non-catastrophic impairment claims (subject to the purchase of optional benefits) the right to make an election is revisited pursuant to subsection 35(2) in cases where a claimant is later determined to have suffered a catastrophic impairment. The logistical consequences of a re-election under section 35(2) are unclear and are not specified in the new SABS (for example, how past benefits will be addressed when a re-election is made after a person has been deemed catastrophic and whether interest applies).

ii. Income Replacement Benefits—Calculation and Accounting Reports

While the \$400 maximum weekly benefit remains (subject to optional benefits), income replacement benefits under the new SABS are to be calculated on the basis of 70% of gross income rather than 80% of net income [s. 7(2)(1)].

Similar to the old SABS, income replacement benefits are not available in the first week post accident. The test for qualifying for income replacement for the first 2 years post accident also remains the same, namely having to establish a “substantial inability” to perform employment tasks. Thereafter, the test for entitlement to income replacement benefits changes to the more difficult test of having a “complete inability” to engage in any suitable employment, based on education, training or experience.

Sections 6(1) and 6(2) state:

6. (1) Subject to subsection (2), an income replacement benefit is payable for the period in which the insured person suffers a substantial inability to perform the essential tasks of his or her employment or self-employment.

(2) The insurer is not required to pay an income replacement benefit,

(a) for the first week of the disability; or

(b) after the first 104 weeks of disability, unless, as a result of the accident, the insured person is suffering a complete inability to engage in any employment or self-employment for which he or she is reasonably suited by education, training or experience.

There are also extensive new definitions for what constitutes self-employed income and how income replacement benefits are to be calculated for self-employed persons [see s.4(3) and s.5(1) and s. 7(3)(b)]. Similar to the test for employed persons, benefits will be calculated based on 70% of the loss from self-employment.

The difficulty with these changes for self-employed persons is that the new test may result in unusually harsh treatment of self-employed persons, by requiring them to establish that their business is actually suffering a loss as defined in the *Income Tax Act*.

While insurers are no longer required to pay for assessment and examination costs out of a separate category of benefits, insurers must use a separate fund to pay for an accounting report used to calculate income replacement benefits. The maximum cost for any such accounting report is \$2,500.

Subsection 7(4) and 7(5) of the new SABS state:

7(4) The insurer shall pay an expense incurred by or on behalf of an insured person for the preparation of a report for the purpose of calculating the person’s income from employment or self-employment if all of the following conditions are satisfied:

1. The insured person is applying for an income replacement benefit under this Part that is based on the employment or self-employment considered in the report.
2. The report is prepared by an accountant licensed under the *Public Accounting Act, 2004* or comparable legislation of the jurisdiction in which the accountant practises.
3. The expense is reasonable and necessary for the purpose of determining the insured person’s entitlement to an income replacement benefit.

7(5) The insurer is not required to pay more than a total of \$2,500 for the preparation of one or more reports under subsection (4) in respect of an insured person.

The combination of the above-noted sections was intended to create a more simplified and cheaper method for establishing entitlement to income replacement benefits. It remains to be seen whether these changes will accomplish that goal.

Furthermore, the change to a 70% of “gross income” calculation as opposed to the previous 80% of “net income” approach will only prove sensible if a corresponding amendment is made to the *Insurance Act* to limit past income loss claims to the same 70% of gross income amount. The *Insurance Act* has not yet been amended in this regard.

iii. Non-Earner Benefits

There has been no change to the criteria for qualifying for non-earner benefits.

To qualify for non-earner benefits you must suffer a “complete inability to carry on a normal life”. Non-earner benefits remain unavailable for the first 26 weeks post accident and remain payable at \$185 per week, subject to being increased to \$320 per week post accident in circumstances where the accident victim had been involved with educational pursuits just before or at the time of the accident.

Sections 12(1) through (4) of the new SABS states as follows regarding the non-earner benefits:

12. (1) The insurer shall pay a non-earner benefit to an insured person who sustains an impairment as a result of an accident if the insured person satisfies any of the following conditions:

1. The insured person suffers a complete inability to carry on a normal life as a result of and within 104 weeks after the accident and does not qualify for an income replacement benefit.
2. The insured person suffers a complete inability to carry on a normal life as a result of and within 104 weeks after the accident and,
 - i. was enrolled on a full-time basis in elementary, secondary or post-secondary education at the time of the accident, or
 - ii. completed his or her education less than one year before the accident and was neither employed nor a self-employed person after completing his or her education and before the accident, in a capacity that reflected his or her education and training.

(2) Subject to subsection (3), the amount of a non-earner benefit is \$185 for each week during the period that the insured person suffers a complete inability to carry on a normal life, less the total of all other income replacement assistance, if any, for the same week.

(3) If a person qualifies for a non-earner benefit under paragraph 2 of subsection (1) and more than 104 weeks have elapsed since the onset of the disability, the amount of the non-earner benefit is \$320 for each week that the insured person suffers a complete inability to carry on a normal life, less the total of all other income replacement assistance, if any, for the same week.

(4) The insurer is not required to pay a non-earner benefit,

- (a) for the first 26 weeks after the onset of the complete inability to carry on a normal life;
- (b) before the insured person is 16 years of age; or
- (c) if the insured person is eligible to receive and has elected under section 35 to receive either an income replacement benefit or a caregiver benefit under this Part.

iv. Caregiver Benefits

Caregiver benefits are now only available to those suffering catastrophic impairments and those who have purchased optional benefits.

With respect to entitlement to caregiver benefits, there has been no change to the criteria for qualifying for caregiver benefits, although entitlement to this benefit may be impacted by the definition of the word “incurred”.

To qualify for caregiver benefits in the first two years post accident an insured must suffer a “substantial inability to engage in the caregiving activities in which he or she was engaged at the time of the accident”. In addition, you must reside with the person in need of care and must be the unpaid primary caregiver for that person. After the two year anniversary of the accident, to qualify for caregiver benefits, you must also pass the non-earner test of suffering a “complete inability to carry on a normal life”.

If incurred, caregiver benefits are paid at a maximum amount of \$250 per week for the first person in need of care, plus \$50 for each additional person in need of care.

Section 13 of the new SABS states as follows regarding the caregiver benefit.

13. (1) The insurer shall pay a caregiver benefit to or for an insured person who sustains a catastrophic impairment as a result of an accident if, as a result of and within 104 weeks after the accident, the insured person suffers a substantial inability to engage in the caregiving activities in which he or she was engaged at the time of the accident and if, at the time of the accident,

- (a) the insured person was residing with a person in need of care, and
- (b) the insured person was the primary caregiver for the person in need of care and did not receive any remuneration for engaging in caregiving activities.

(2) The caregiver benefit shall pay for reasonable and necessary expenses incurred as a result of the accident in caring for a person in need of care, but shall not exceed,

- (a) \$250 per week for the first person in need of care; and
- (b) \$50 per week for each additional person in need of care.

(3) Despite subsection (1), no caregiver benefit is payable to an insured person if he or she is eligible to receive and has elected under section 35 to receive either an income replacement benefit or a non-earner benefit under this Part.

(4) Despite subsection (1), no caregiver benefit is payable for any period longer than 104 weeks of disability unless, as a result of the accident, the insured person is suffering a complete inability to carry on a normal life.

e) CATASTROPHIC IMPAIRMENT CHANGES:

i. Definition and Timing of the Application

One positive change in the new SABS is the expanded definition of “catastrophic impairment” to cover single limb amputees. However, on the negative side, subsection 3(5) creates serious obstacles for insured persons in terms of the timing of the application for catastrophic designation in certain circumstances.

The introduction of the single limb amputee section served to amalgamate what was formerly clauses (b) and (c) of the catastrophic impairment definition and as a result the various tests have all moved up a letter.

The “catastrophic impairment” definition in section 3(2) and the related interpretation sections (sections 3(3), 3(4), 3(5) and 3(6)) are as follows:

- 3 (2) For the purposes of this Regulation, a catastrophic impairment caused by an accident is,
- (a) paraplegia or quadriplegia;
 - (b) the amputation of an arm or leg or another impairment causing the total and permanent loss of use of an arm or a leg;
 - (c) the total loss of vision in both eyes;
 - (d) subject to subsection (4), brain impairment that results in,
 - (i) a score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., *Management of Head Injuries*, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or {See timing restrictions in s. 3(5) below}
 - (ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;
 - (e) subject to subsections (4), (5) and (6), an impairment or combination of impairments that, in accordance with the American Medical Association’s *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in 55 per cent or more impairment of the whole person; or {See timing restrictions in s. 3(5) below}
 - (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. {See timing restrictions in s. 3(5) below}
- (3) Subsection (4) applies if an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association’s *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, referred to in clause (2) (d), (e) or (f) can be applied by reason of the age of the insured person.
- (4) For the purposes of clauses (2) (d), (e) and (f), an impairment sustained in an accident by an insured person described in subsection (3) that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in clause (2) (d), (e) or (f), after taking into consideration the developmental implications of the impairment.
- (5) Clauses (2) (e) and (f) do not apply in respect of an insured person who sustains an impairment as a result of an accident unless,
- (a) in the case of an impairment that includes a brain impairment, a physician states in writing that the insured person’s condition is unlikely to cease to be a catastrophic impairment;

- (b) in the case of an impairment that is only a brain impairment, a neuropsychologist states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or
- (c) two years have elapsed since the accident.

(6) For the purpose of clauses (2) (e) and (f), an impairment that is sustained by an insured person but is not listed in the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 is deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

With respect to when an application for catastrophic impairment can be made, subsection 3(5) now stipulates that the whole person impairment test (s. 3(2)(e)) and the marked or extreme impairment test (s. 3(2)(f)) can only be considered prior to the 2 years post accident mark if the impairment includes a brain injury and if the impairment is unlikely to cease to be a catastrophic impairment. Previously, these tests could be accessed before the 2 year mark without the need for a brain injury.

With the reduction of the non-catastrophic medical/rehabilitation limit to \$50,000 and the reduction in attendant care limit to \$36,000, many claimants that are later determined to have suffered a "catastrophic impairment" will have run out of benefits long before they are able to apply for catastrophic impairment designation. This problem is exacerbated by the fact that the injured party will have to fund the costs of the assessments to prove that their injury is catastrophic on their own, since assessment costs are now paid out of medical and rehabilitation limits and those limits will have been exhausted.

Another potentially important addition to the new SABS is the reference in section 44(2) to a Guideline that may specify "conditions, restrictions or limits" with respect to the determination of whether an impairment is a catastrophic impairment.

Sections 44(1) and (44(2) state as follow:

44. (1) For the purposes of assisting an insurer to determine if an insured person is or continues to be entitled to a benefit under this Regulation for which an application is made, but not more often than is reasonably necessary, an insurer may require an insured person to be examined under this section by one or more persons chosen by the insurer who are regulated health professionals or who have expertise in vocational rehabilitation.

(2) Despite subsection (1), if a Guideline specifies conditions, restrictions or limits with respect to the determination of whether an impairment is a catastrophic impairment and the purpose of the examination is to determine whether the insured person has sustained a catastrophic impairment, the determination must be made in accordance with those conditions, restrictions and limits.

It is unclear how any Guideline pursuant to section 44(2) may be used. It had been thought that this provision was inserted to provide the ability to later specify requisite training or experience required before a physician or neuropsychologist was eligible to complete an application for catastrophic impairment; however, the wording of section 44(2) has raised concern over the ability to modify the definition and interpretation of the term "catastrophic impairment" by way of a Guideline. It is expected that any Guideline which purports to narrow the definition or interpretation of the term "catastrophic impairment" will be

challenged in the Courts as an improper attempt to legislate substantive changes under the guise of a Guideline.

ii. Physician/Neuropsychologist to Sign CAT application

Only a physician or neuropsychologist can complete an assessment or examination and sign an application for catastrophic designation pursuant to section 45(2).

Sections 45(1) and 45(2) state:

45. (1) An insured person who sustains an impairment as a result of an accident may apply to the insurer for a determination of whether the impairment is a catastrophic impairment.

(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.

iii. Payment of Attendant Care Benefits Pending CAT Determination

Similar to the old SABS, the new SABS allow attendant care benefits to continue to flow to a claimant, at the higher monthly limits, in certain circumstances where an application for catastrophic impairment has been made.

Section 45(4) of the new SABS provides that if a person is receiving attendant care benefits at the time an application for catastrophic impairment is made, the insurer is required to continue paying those attendant care benefits, at the catastrophic rates, pending the catastrophic impairment determination.

45. (4) If an application is made under this section not more than 104 weeks after the accident and, immediately before the application was made, the insured person was receiving attendant care benefits,

- (a) the insurer shall continue to pay attendant care benefits to the insured person during the period before the insurer makes a determination under this section; and
- (b) the amount of the attendant care benefits for the period referred to in clause (a) shall be determined on the assumption that the insured person's impairment is a catastrophic impairment.

Under the old SABS, this provision was very useful to extend attendant care benefits (at the increased monthly maximums) by submitting an application for catastrophic designation (such as in cases where the two year anniversary was approaching and a claim could be made at that time under sections 3(2)(e) or (f)).

However, under the new SABS the timing for access to the application for catastrophic impairment has been delayed in certain cases not involving a brain injury. Moreover, since attendant care benefits have been reduced to \$36,000 for non-catastrophic cases, if an insured is receiving attendant care benefits at

the non-catastrophic maximum rate of \$3,000 per month, those benefits will last only 1 year. Consequently, this person will not qualify for access to this provision (and the extension of the attendant care benefits at the enhanced maximums) because they are not receiving attendant care benefits at the time they make their catastrophic application.

The effect of this section is that the claimant's personal injury lawyer will, in potentially catastrophic cases, have to strategically manage to hold back some of the claimant's attendant care benefits, and not receive them, until just before the time they apply for the catastrophic impairment determination.

f) MINOR INJURIES:

i. Minor Injury Definition and Process

The new SABS replaces the Pre-Approved Framework with the minor injury provisions and the associated Minor Injury Guideline.

In the new SABS a "minor injury" has been defined as a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae. Many of these terms are also defined in the new SABS.

The various definitions associated with the "minor injury" process are found in section 3(1) of the new SABS and are as follows:

3. (1) In this Regulation,

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

"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;

"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

(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.

The definition of "minor injury" appears to have been intended to cover claims formerly caught by the definition of WADI and WADII. The definitions in the new SABS extend far beyond what medical practitioners would normally view as

sprains, strains and whiplash associated disorders. These definitions also seem to ignore severity and issues of objective verification.

The definition of “strain” is problematic because it includes tears of tendons and ligaments. For example, one question is whether a significantly torn rotator cuff (but not completely torn), which would currently be viewed as a serious injury, would be caught by this new definition of “strain”, and therefore be confined to the minor injury provisions. Although many of the definitions relating to “minor injury” appear to be quite broad, it is hoped that insurers don’t try to use these expansive definitions to categorize many serious cases as minor injuries.

ii. Minor Injury Guideline

With respect to the Minor Injury Guideline, at the time of writing this paper, the Guideline is not yet available for publication. The Minor Injury Guideline is expected to set out a detailed treatment framework for minor injuries.

Hopefully, the Guideline will clarify whether someone escaping the \$3,500 minor injury medical and rehabilitation maximum is no longer considered to have suffered a “minor injury” and is therefore eligible for items such as attendant care benefits.

g) OTHER SIGNIFICANT CHANGES:

i. Interest on Overdue Benefits Reduced

The interest rate chargeable on overdue accident benefit payments has been reduced to 1% per month compounded monthly from 2% per month compounded monthly.

Subsection 51(2) states:

51. (2) If payment of a benefit under this Regulation is overdue, the insurer shall pay interest on the overdue amount for each day the amount is overdue from the date the amount became overdue until it is paid, at the rate of 1 per cent per month, compounded monthly.

This reduced compound interest rate relaxes the very real and significant penalty associated with an insurer acting unreasonably.

We understand that, for outstanding benefits that remain unpaid as of September 1, 2010, the 2% per month compounded rate will continue to apply after September 1st, but additional guidance on the application of these type of transitional issues are expected from the Financial Services Commission of Ontario.

ii. Benefit Statements

Under the new SABS, insurers must deliver benefit statements to claimants setting out the amounts paid to date in medical/rehabilitation benefits and attendant care benefits. In non-catastrophic impairment cases, insurers are required to send out a benefit statement every 2 months, unless there has been no change in the amount of benefits used. In catastrophic impairment cases a benefit statement must be sent out every 12 months.

Section 50 sets out the benefit statement requirement. It states:

50. (1) When a benefit is first paid or the amount of a benefit is subsequently changed, the insurer shall provide the insured person with a written explanation of how the amount of the benefit was determined.

(2) While medical, rehabilitation or attendant care benefits are being claimed by or are being paid to or on behalf of an insured person, the insurer shall deliver benefit statements to the insured person in accordance with this section.

(3) A benefit statement required under subsection (2) shall include a statement of,

- (a) the amount paid to the date of the benefit statement in respect of medical and rehabilitation benefits;
- (b) the additional amount remaining in respect of medical and rehabilitation benefits, taking into account the applicable maximum limits referred to in sections 18 and 28, if the insured person were to be entitled to payment of those benefits;
- (c) the amount paid to the date of the benefit statement in respect of attendant care benefits;
- (d) the additional amount remaining in respect of attendant care benefits, taking into account the applicable maximum limits referred to in sections 20 and 28, if the insured person were to be entitled to payment of attendant care benefits; and
- (e) the amount paid by the insurer to the date of the benefit statement in respect of examinations conducted under section 44.

(4) Subject to subsection (5), the benefit statements must be delivered at the following times:

- 1. If it has been determined that the insured person has sustained a catastrophic impairment as a result of the accident, a benefit statement must be delivered at least once a year, commencing not later than 12 months after the date the insured person was determined to have sustained the catastrophic impairment.
- 2. In any other case, a benefit statement must be delivered at least once every two months, commencing not later than two months after the application for the benefit was first made.

(5) Despite subsection (2), an insurer is not required to deliver a benefit statement if all of the amounts referred to in subsection (3) are unchanged from the amounts set out in the most recent benefit statement delivered in accordance with this section.

It may be that by providing regular benefit statements to claimants, they will be better able to manage the limited medical, rehabilitation and attendant care benefits available to them.

Benefit statements are not required for accidents that predate September 1, 2010. Section 2(2) of the new SABS expressly exempts the application of sections 50(2) to 50(5) (the requirement for benefit statements) for accidents before September 1, 2010.

iii. Discretion for Adjusters to Deny Benefits

Under the new SABS, adjusters have been given discretion to deny benefits for "medical and any other reasons" without requiring an examination. Previously, any potential denials had to be sent by the insurer for an insurer examination. Now insurers are empowered to deny benefits without an insurer examination.

Section 37(4) provides the following discretion to adjusters to deny specified benefits without an insurer examination:

37. (4) If the insurer determines that an insured person is not entitled or is no longer entitled to receive a specified benefit on any one or more grounds set out in subsection (2), the insurer shall advise the insured person of its determination and the medical and any other reasons for its determination.

Section 38(8) provides the following discretion to adjusters to deny medical and rehabilitation benefits (requested by way of a "treatment and assessment plan") without an insurer examination:

38. (8) Within 10 business days after it receives the treatment and assessment plan, the insurer shall give the insured person a notice that identifies the goods, services, assessments and examinations described in the treatment and assessment plan that the insurer agrees to pay for, any the insurer does not agree to pay for and the medical and any other reasons why the insurer considers any goods, services, assessments and examinations, or the proposed costs of them, not to be reasonable or necessary.

Section 42(3) provides the following discretion to adjusters to deny attendant care benefits without an insurer examination:

42. (3) Within 10 business days after receiving the assessment of attendant care needs, the insurer shall give the insured person a notice that specifies the expenses described in the assessment of attendant care needs the insurer agrees to pay, the expenses the insurer refuses to pay and the medical and any other reasons for the insurer's decision.

Section 45(3) provides the following discretion to adjusters to deny catastrophic impairment applications without an insurer examination:

45. (3) Within 10 business days after receiving an application under subsection (1) prepared and signed by the person who conducted the assessment or examination under subsection (2), the insurer shall give the insured person,

- (a) a notice stating that the insurer has determined that the impairment is a catastrophic impairment; or
- (b) a notice stating that the insurer has determined that the impairment is not a catastrophic impairment and specifying the medical and any other reasons for the insurer's decision and, if the insurer requires an examination under section 44 relating to whether the impairment is a catastrophic impairment, so advising the insured person.

It is unclear how adjusters will use their discretion. Some will argue that by the wording of the section, an adjuster must give at the very least, a medical reason for the denial along with any other reasons for the denial. Realistically, because insurance adjusters generally have no formal medical training to be giving a medical reason or opinion for denial on their own, they will, at least initially, be leery of denying benefits without an insurer examination to rely upon. Given their past experience and familiarity with requiring insurer examinations to support the medical basis for a denial under the current SABS, insurers will likely follow the same approach before denying benefits under the new SABS. An insurer

examination helps insulate adjusters from the criticism that they are attempting to make medical determinations without any formal medical training.

Any adjuster that does use their discretion to deny a benefit will do so at the risk of being accused of acting without a proper medical reason to deny the benefits and, moreover, will face the prospect of an Arbitration without a medical opinion to support their position.

iv. Unfair and Deceptive Acts and Practices Changes

The Regulation relating to Unfair and Deceptive Acts and Practices, O. Reg. 7/00 has also been amended by amending Regulation 37/10.

Section 6 has been added, as of September 1, 2010, to the Unfair and Deceptive Acts and Practices Regulation to address an insurer's failure, without reasonable cause, to pay a claim for goods or services or the costs of an assessment within the time prescribed in the new SABS.

Section 6 of the Unfair and Deceptive Acts and Practices Regulation now states:

6. For the purposes of the definition of “unfair or deceptive acts or practices” in section 438 of the Act, each of the following actions is prescribed as an unfair or deceptive act or practice in relation to a claim for statutory accident benefits under the *Statutory Accident Benefits Schedule* — *Effective September 1, 2010, made under the Act (in this section referred to as the Schedule)*:

1. The failure or refusal of an insurer without reasonable cause to pay a claim for goods or services or for the cost of an assessment within the time prescribed for payment in the *Schedule*.
2. The making of a statement by or on behalf of an insurer for the purposes of an adjustment or settlement of a claim if the insurer knows or ought to know that the statement misrepresents or unfairly presents the findings or conclusions of a person who conducted an examination under section 44 of the *Schedule*. O. Reg. 37/10, s. 3.

This provision had already been in place regarding the old SABS and therefore this change is of no consequence. However, it is noted that the provisions of the Unfair and Deceptive Acts and Practices Regulation dealing with the old SABS prohibits denying benefits without an insurer examination report and, because under the new SABS adjusters have some discretion to deny benefits without an insurer examination, this provision does not apply to the new SABS.

h) OPTIONAL BENEFITS:

Optional benefits have been available in Ontario for some time, although they have not been very popular.

The new SABS provides consumers with a number of new optional benefits, including optional benefits designed to restore the benefit reductions to the old SABS levels.

Under the new SABS the following optional benefits are available:

- a) An optional income replacement benefit that increases the maximum weekly amount from \$400 to either \$600, \$800 or \$1,000 per week (see paragraph 1 of section 28(1));
- b) An optional caregiver benefit (see paragraph 2(i) of section 28(1));
- c) An optional housekeeping benefit for the first 2 years post accident (see paragraph 2(ii) of section 28(1));
- d) An optional medical and rehabilitation benefit of up to \$100,000 in non-catastrophic situations (see paragraph 3 of section 28(1));
- e) An optional attendant care benefit of up to \$72,000 in non-catastrophic situations (see paragraph 4 of section 28(1));
- f) An optional medical, rehabilitation and attendant care benefit that provides (see paragraph 5 of section 28(1));
 - i) in non-catastrophic cases:
 1. increases the maximum medical and rehabilitation benefits to \$1,100,000;
 2. is not limited to the 10 year (or age 25) criteria for medical and rehabilitation benefits;
 3. provides case management services (as specified in section 17(1)(b));
 4. increases the attendant care benefit limit to \$1,072,000 (but no attendant care is available for minor injuries still); and,
 5. but is restricted to total medical/rehabilitation and attendant care benefits of \$1,172,000.
 - ii) in catastrophic cases:
 1. increases the maximum medical and rehabilitation benefits to \$2,000,000;
 2. increases the attendant care benefit limit to \$2,000,000; and,
 3. but is restricted to total medical/rehabilitation and attendant care benefits of \$3,000,000.
- g) An optional death and funeral benefit that doubles the amounts otherwise available and increases the funeral expense maximum to \$8,000 (see paragraph 6 of section 28(1));
- h) An optional dependant care benefit (see paragraph 7 of section 28(1) and see section 29); and,
- i) An optional indexation benefit (see paragraph 8 of section 28(1) and see section 30).

An education component is being designed to help educate the public about these options and the merits of purchasing these options.

It may be that lawsuits are eventually brought against insurance brokers who, in certain circumstances, fail to advise customers of certain optional benefits.

One new option is the option to buy down a portion of the statutory deductible that applies in tort claims. Realistically this option is of virtually no appeal and is impossible to understand for the common policy holder. It would only apply in cases where the at-fault driver is successfully sued and the accident victim has injuries that meet the threshold definition (permanent and serious injuries that exceed the defining Regulation) and has general damages (or claims under the Family Law Act of Ontario) that are less than the vanishing deductible thresholds.

We note that the SABS changes do not address the promise made by the Government regarding the elimination of the statutory deductible in tort fatality cases. It is hoped that this important change will soon be part of necessary amendments to the *Insurance Act*.

With respect to access to optional benefits that are purchased, it should be understood that, pursuant to section 28(2), only the named insured, the spouse of the named insured, their dependants and persons specified in the policy as drivers of the insured automobile, qualify for access to optional benefits.

i) TRANSITIONAL ISSUES:

Because of the importance of the topic of transitional issues, a separate paper has been prepared by Thomson, Rogers addressing this issue in greater detail. It is also noted that the Financial Services Commission of Ontario has expressed an intention to provide further guidance on transitional issues relating to the new SABS, although this information is not available at this time.

For persons in accidents prior to September 1, 2010 they maintain access to the various benefits available under the old SABS. For example, non-catastrophic accident victims can still access caregiver benefits or housekeeping and home maintenance benefits after September 1, 2010 (assuming they qualify).

To incorporate claims that predate September 1, 2010 into the new SABS process, the old SABS have been amended by Ontario Regulation 35/10. Amending Reg. 35/10 makes it clear that certain items like the \$2,000 assessment/examination cap will apply to these old claims and that no rebuttal reports are available.

Ontario Regulation 35/10 amends the old SABS (O. Reg. 403/96) by replacing section 3(1) of the old SABS with the following:

3. (1) In this section,

“New Regulation” means Ontario Regulation 34/10 (Statutory Accident Benefits Schedule — Effective September 1, 2010), made under the Act.

(1.1) Subject to subsection (1.3), the benefits set out in this Regulation shall be provided under every contract evidenced by a motor vehicle liability policy in respect of accidents that occur on or after November 1, 1996 and before September 1, 2010.

(1.2) Section 24 and Parts X, XI, XII, XIII and XV do not apply after August 31, 2010.

(1.3) No amount referred to in this Regulation shall be paid after August 31, 2010.

(1.4) An amount that would, but for subsection (1.3), be paid under this Regulation after August 31, 2010 shall be paid under the New Regulation, but in the amount determined,

(a) under this Regulation, other than section 24 {"cost of examinations" section of old SABS}; or

(b) under subsections 25 (1), (3), (4) and (5) of the New Regulation {various "cost of examination" provisions under the new SABS}.

With respect to the \$2,000 assessment cap, section 3(1.4) makes it clear that these costs (formerly under section 24) are to be dealt with under the new section 25 and are thus subject to the cap. While some health practitioners have been advised that the \$2,000 cap will apply to approved treatment plans that have been invoiced prior to September 1, 2010 it remains unclear whether or not this will in fact be the case. It may be more likely that insurers will be required to pay approved treatment and assessment plans over the \$2,000 cap even if they are invoiced after September 1, 2010 given what may be contractual obligations in that regard or since these expenses were approved and are being paid in accordance with former section 24 of the old Regulations and not truly under section 25 (as, for example, they are not likely technically associated with a "treatment and assessment plan under the new SABS provisions).

The balance of section 3(1) of the amended old SABS makes it clear that no procedural steps should be taken under the old SABS after September 1, 2010.

Corresponding provisions have been included in the new SABS confirming the provisions of the old SABS that apply to pre September 1, 2010 claims.

Sections 2(1) and 2(2) of the new SABS states:

2. (1) Except as otherwise provided in section 68, the benefits set out in this Regulation shall be provided under every contract evidenced by a motor vehicle liability policy in respect of accidents occurring on or after September 1, 2010.

(2) Subsections 25 (1), (3), (4) and (5), Parts VIII and IX, other than subsections 50 (2) to (5), and Parts X, XI and XII apply with such modifications as are necessary in respect of benefits provided under the Old Regulation with respect to accidents that occurred on or after November 1, 1996 and before September 1, 2010 and, for that purpose, the following rules apply:

1. References in paragraph 2 of subsection 25 (1), subsections 38 (1), (5), (7), (9), (10), (11), (12) and (14), sections 40 and 41 and subsection 44 (3) to the Minor Injury Guideline shall be read as references to the *Pre-approved Framework Guideline* referred to in the Old Regulation that would apply.
2. An amount that would, but for subsection 3 (1.3) of the Old Regulation, be paid under the Old Regulation after August 31, 2010 shall be paid under this Regulation in the amount determined,
 - i. under the Old Regulation, other than under section 24 of that Regulation, or

- ii. under subsections 25 (1), (3), (4) and (5).
3. An amount described in paragraph 2 that is paid under this Regulation shall not include any amount previously paid under the Old Regulation.

What remains unclear from the amendment to the old SABS is what is meant by the reference to “an amount” being determined under the old SABS (as stated in section 3(1.4) of the amended old SABS). When it comes to the “amount” for income replacement benefits it is clear that the old SABS rule of 80% net will apply. But when it comes to the “amount” of attendant care payable under the old SABS, is the former meaning of “incurred” incorporated or does the new definition of “incurred” apply to these old accident benefit claims. In addition, are assessments costs to be paid out of medical and rehabilitation benefits for these older accident benefit claims?

Representatives of FSCO have advised us that for accidents that occurred before September 1, 2010, the new SABS definition of “incurred” and the requirement that assessments/examinations costs be paid out of medical and rehabilitation limits, do not apply.

For accidents victims after September 1, 2010 that are subject to an old policy (that has not yet been renewed), section 68 of the new SABS stipulates that the various benefits formerly available under the old SABS will still remain. However, these claims will be subject to the balance of the new SABS provisions that negatively impact the entitlement of accident victims, such as the provision that assessment costs are to be paid out of medical and rehabilitation limits and such as the new definition of “incurred” (as well as the \$2,000 assessment and examination cap).

Section 68 states:

68. (1) Despite any other provision of this Regulation and unless otherwise agreed in writing by the named insured and the insurer, subsection (2) applies to every motor vehicle liability policy that is in effect on September 1, 2010 until the earlier of,

- (a) the first expiry date under the motor vehicle liability policy; and
- (b) the day on which the motor vehicle liability policy is terminated by the insurer or the insured, if the policy is terminated before the day referred to in clause (a).

(2) The following benefits are deemed to be included in the motor vehicle liability policy and are applicable to an insured person in respect of the motor vehicle liability policy:

1. The optional caregiver, housekeeping and home maintenance benefit referred to in paragraph 2 of subsection 28 (1).
2. The optional medical and rehabilitation benefit referred to in paragraph 3 of subsection 28 (1).
3. The optional attendant care benefit referred to in paragraph 4 of subsection 28 (1).
4. All optional benefits referred to in subsection 27 (1) or section 28 or 29 of the Old Regulation that were purchased and still in effect on September 1, 2010.

Because of these important transitional issues, claimants involved in accidents after September 1, 2010 will have to carefully review whether their policy is an old SABS policy or whether it is a new SABS policy.

2) SUMMARY OF BENEFITS UNDER THE NEW SABS

The new SABS contain many of the old categories of accident benefits with identical monetary limitations.

Most of the changes in the new SABS deal with a reduction of the accident benefits available in non-catastrophic cases.

Below is a summary of the common accident benefits that remain available followed by a summary of the accident benefits now available under the new SABS for the three different levels of impairment: minor injury, non-catastrophic impairment and catastrophic impairment.

Please note that the benefit summary below is based on the standard auto policy but it is noted that optional benefits are available to enhance many of the benefits set out below.

a) COMMON ACCIDENT BENEFITS (largely unchanged):

The following benefits remain available to all accident benefit claimants, subject to meeting the new definition of “incurred”, if applicable, and subject to enhanced benefits by virtue of optional benefits:

- i) **Lost Educational Expenses** (section 21)—Up to \$15,000 is payable to those enrolled in school that are unable to continue with their program.
- ii) **Visitor's Expense** (section 22)—To reimburse certain immediate family members for their expenses visiting an injured person (note that this benefit is available for life in catastrophic impairment cases but is otherwise only available for the first 2 years post accident).
- iii) **Damage to Clothing and Medical Devices** (section 24)—Reimbursement for damage to clothing, medical and dental devices lost or damaged in the accident (no limit).
- iv) **Death Benefits** (section 26)—In cases of fatality, a payment of \$25,000 to a spouse, \$10,000 to a supported former spouse and \$10,000 per dependant (or more if there is no spouse).
- v) **Funeral Benefits** (section 27)—Paid up to a \$6,000 maximum in cases of fatality.

- vi) **Transportation Expenses** (sections 15(1)(g) & 16(3)(k))—Available in catastrophic cases, but in all other cases the insurer is only responsible for the portion of the distance over 50 kms when attending assessments, examinations or treatment. Now defined as “authorized transportation expenses” in section 3(1).
- vii) **Non-Earner Benefits** (section 12)—Available as a weekly benefit in certain cases where the person has suffered a complete inability to carry on a normal life—paid at \$185 per week, and can be increased to \$320 per week after the 2 year anniversary of the accident in cases where the accident victim had been involved with educational pursuits soon before or at the time of the accident (not available for the first 26 weeks).
- viii) **Income Replacement Benefits** (sections 6 and 7)—Available as a weekly benefit in cases where the person is unable to return to work or self-employment—but now paid at 70% of gross income rather than at 80% of net income to the same maximum of \$400 per week (not payable for the first week post accident and the qualifying test changes at the two year anniversary).

b) MINOR INJURY ENTITLEMENT:

Those suffering from Minor Injuries are, subject to the purchase of optional benefits, entitled to the following benefits, in addition to the benefits set out above:

i. Medical and Rehab Benefits (sections 15, 16, 18 & 20)

A maximum of \$3,500 is available for medical and rehabilitation benefits in minor injury cases.

The \$3,500 maximum set out in section 18(1) of the new SABS can be increased to \$50,000 in accordance with section 18(2) if there is compelling evidence that a pre-existing medical condition will prevent the insured person from achieving maximal recovery if they are subject to the \$3,500 cap.

Sections 18(1) and 18(2) state:

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.

It is odd that the escape clause in s. 18(2) is limited to people who have a pre-existing medical condition which prevents maximal recovery within the limits provided by the Minor Injury Guideline. What about people who simply do not respond to treatment or recover as quickly as others. What is the rationale for not permitting them to escape the minor injury guideline, if they do not have a pre-existing condition? For example, older people may not recover as quickly as younger people. Is their age to be considered a “pre-existing condition” which impairs their recovery?

It is anticipated that the Minor Injury Guideline will provide details of the treatment available for minor injury claims.

Notably, in-home assessments and examinations are not available in minor injury cases pursuant to section 25(2).

Section 25(2) states:

25. (2) Despite subsection (1) {what insurer must pay for}, an insurer is not required to pay for an assessment or examination conducted in the insured person’s home unless the insured person has sustained an impairment that is not a minor injury.

It is somewhat unclear whether someone that escapes the \$3,500 medical and rehabilitation limit in section 18(2) is still considered to have suffered a “minor injury”. However, we can advise that representatives of FSCO have indicated that a person escaping the \$3,500 maximum pursuant to section 18(2) will still be considered to have suffered a “minor injury” and would therefore remain ineligible for attendant care benefits and ineligible for in-home assessments/examinations.

ii. Attendant Care Benefits (not available)

Attendant care benefits are not available to minor injury claimants pursuant to paragraph 5(ii)(C) of subsection 28(1).

iii. Housekeeping and Home Maintenance Benefits (not available)

Housekeeping and Home Maintenance Benefits are not available to persons suffering a minor injury pursuant to section 23.

iv. Caregiver Benefits (not available)

Caregiver benefits are not available to persons with minor injuries as set out in section 13.

v. Income Replacement Benefits

There is no constraint on access to income replacement benefits in minor injury claims (unless so stipulated in the yet to be released Minor Injury Guideline). This is a welcome change from the old SABS, as section 5(1)(d) and 5(1)(e) of the old SABS limited income replacement benefits to 12 or 16 weeks in WADI and WADII cases.

c) NON-CATASTROPHIC IMPAIRMENT CLAIMS

i. Medical and Rehab Benefits (sections 18 and 20)

A maximum of \$50,000 in medical and rehabilitation benefits is available for 10 years or until the person is 25 years old as set out in section 18(3)(a) and 20(1) of the new SABS. The old SABS had a limit of \$100,000.

In addition, the cost of assessments, examinations and preparing reports will be paid out of a claimant's medical and rehabilitation limits pursuant to section 18(5). Previously assessment costs had been paid by the insurer out of a separate category of benefits over and above the medical and rehabilitation limit.

ii. In-Home Assessments and Examination

In-home assessments and examinations are allowed, in accordance with section 25(2). There had been concern that the new SABS would preclude in-home assessments in non-catastrophic cases but the final version of the new SABS thankfully does not include any such prohibition.

iii. Case Manager Services (not available)

As set out in section 17, the services of a case manager are not available in non-catastrophic impairment cases, unless optional benefits provide otherwise.

iv. Attendant Care Benefits

The \$3,000 per month maximum remains in the new SABS (see paragraph 1(i) of subsection 19(3)) for the same period of up to 2 years post accident (see section 20(2)); however, the total maximum available in attendant care has been reduced to \$36,000 (from \$72,000), pursuant to paragraph 2(ii) of subsection 19(3) of the new SABS.

Only an occupational therapist or a registered nurse may now complete an attendant care assessment (see section 42(1)(b)) and of course the definition of “incurred” in section 3(7)(e) becomes an important factor.

v. Housekeeping and Home Maintenance Benefits (not available)

Housekeeping and Home Maintenance Benefits are not available to persons suffering a non-catastrophic injury pursuant to section 23 (subject to optional benefits).

vi. Caregiver Benefits (not available)

Caregiver benefits are now not available to persons with non-catastrophic injuries as set out in section 13 (subject to optional benefits). Previously, caregiver benefits were available to non-catastrophic claimants.

d) CATASTROPHIC IMPAIRMENT CLAIMS:

i. Medical and Rehab Benefits (sections 18 and 20)

There remains a maximum of \$1,000,000 available for medical and rehabilitation benefits in catastrophic impairment cases (section 18(3)(b)). These benefits are available over the claimant’s lifetime.

However, the cost of assessments, examinations and preparing reports will now be paid out of medical and rehabilitation limits pursuant to section 18(5). Previously assessment costs had been paid by the insurer out of a separate category of benefits over and above the medical and rehabilitation limit.

ii. In-Home Assessments and Examinations

In-home assessments and examinations are allowed, in accordance with section 25(2).

iii. Case Manager Services

As set out in section 17 of the new SABS, the services of a case manager are available in catastrophic impairment cases. The cost of the case manager is paid out of medical and rehabilitation limits in accordance with section 17(1).

iv. Attendant Care Services

Attendant care benefits remain available at \$6,000 per month for life in catastrophic impairment cases with a maximum limit of \$1,000,000 (see paragraph 1(ii) and paragraph 2(i) of subsection 19(3)).

Only an occupation therapist or a registered nurse may now complete an attendant care assessment (see section 42(1)(b)) and of course the definition of “incurred” in section 3(7)(e) becomes an important factor.

v. Housekeeping and Home Maintenance Benefits

In catastrophic impairments cases, housekeeping and home maintenance benefits are available at \$100 per week for life pursuant to section 23. These expenses must now meet the new definition of “incurred” in section 3(7)(e).

vi. Caregiver Benefits

In catastrophic impairment cases, if a person is substantially unable to engage in caregiver activities, then a weekly benefit is available at \$250 a week for the first person in need of care plus \$50 a week for all other persons in need of care, pursuant to section 13. Caregiver benefits are only available after the 2 year anniversary of the accident though if the person suffers a complete inability to carry on a normal life (meets the non-earner test).

Note though that a claimant can elect to receive only one of the weekly benefits (income replacement benefits, non-earner benefits or caregiver benefits) and must make an irreversible election in that regard pursuant to section 35.

CONCLUSION

The reductions in accident benefits set out in the new SABS will have detrimental impacts on many seriously injured persons in Ontario. Hopefully, the public will be educated on the utility of optional benefits and that the purchase of optional benefits will become the norm rather than the exception.

In the coming weeks and months before the September 1st, 2010 implementation date of the new SABS, further announcements are expected from the Financial Services Commission of Ontario clarifying a number of questions and issues raised in this paper, such as transitional issues. In addition, Guidelines, such as the Minor Injury Guideline, should soon be available.

Updated information regarding the interpretation of the new SABS will be posted at www.thomsonrogers.com along with any new Guidelines.

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