Life after DACs

Working for Adults and Children with Brain Injury Within the New Post-DAC System

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Comparison of Existing Legislation (DAC System) to Post-DAC System

Benefit & Section Number	EXISTING LEGISLATION (DAC System)	Post-DAC System	Comment
DEFINITION s. 2(1) "Assessment of Attendant Care Needs"	➢ No comparable definition, however old system had a procedure for requesting assessments including attendant care	➢ "Assessment of Attendant Care Needs " means a written assessment of attendant care needs that satisfies the requirements of s. 39	➢ The old system of requesting an assessment is replaced by this section ➢ See s. 39 below for entire process ➢ An application for attendant care benefits now must be in the form of an Assessment of Attendant Care Needs which begins the process
DEFINITION s. 2(1) "Disability Certificate"	➢ Disability Certificate under s. 34 required for IRB, non-earner, caregiver, education benefit	➢ A certificate from a health care practitioner of the insured person's choice which states - the cause and nature of the impairment - contains an estimate of the duration of the disability	➢ This new certificate is required for virtually every benefit claimed ➢ Insurer entitled to request disability certificates as often as reasonably necessary to determine entitlement to benefits

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DEFINITION "Specified Benefits" S. 35 & S. 37 & S. 32	➢ Under old legislation called ➢ Income replacement benefit ➢ Non-earner benefit ➢ Caregiver benefit ➢ Housekeeping and home maintenance benefit	➢ All of these are now referred to as "SPECIFIED BENEFITS"	➢ See sections below on procedure for claiming these benefits
LOST EDUCATIONAL BENEFITS s. 20	➢ Benefit if person cannot continue in elementary, secondary, post – secondary or continuing education program ➢ Benefit not to exceed $15,000.00	➢ Same type of benefit for same type of loss of ability to continue with education ➢ Expanded rights to the insurer's ability to request disability certificates to substantiate the claim	➢ Insurer may request a disability certificate as often as is reasonably necessary ➢ Insured must supply a NEW disability certificate (completed as of date of request) within 15 days of request ➢ No benefit payable until person furnishes the disability certificate
EXAMINATION COSTS Reviewing Treatment Plan	➢ …a health practitioner for reviewing a **treatment plan** under section 38, and for approving it, if appropriate.	➢ …reasonable fees charged by a health practitioner for s. 38 review and approval of a treatment plan	➢ No change.

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EXAMINATION COSTS Preparing an Application for Approval of an Assessment	➢ …a member of a health profession for preparing an application for approval of an assessment or examination under s. 38.2	➢ …Same with addition of social worker.	➢ No material change.
EXAMINATION COSTS Preparing an Assessment of Attendant Care Needs	➢ …a member of a health profession for preparing an assessment of attendant care needs under s. 39	➢ …No change.	
EXAMINATION COSTS Preparing an Application for CAT determination	➢ …a health practitioner for preparing an application for a determination of catastrophic under s. 40 ➢ …for a designated assessment	➢ …No change.	

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EXAMINATION COSTS Preparing a PAF treatment confirmation form	➢ …by a health professional in accordance with a Pre-approved Framework Guideline for preparing a treatment confirmation form for the purposes of s. 37.1	➢ …fees charged in accordance with a pre-approved framework…s. 37.1	➢ No change.
EXAMINATION COSTS PAF Exam or Assessment and Report	➢ …by a member of a health profession in accordance with a PAF guideline for conducting an assessment or examination and preparing a report for the purposes of s. 37.1	➢ …No change	

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EXAMINATION COSTS **Consultation By An IE Doctor With A Treating Health Provider** **s. 24.1(1)1** **s. 24.1(1)2** **s.24.1(1) 3**		➢ …Subject to s. 24.1(2), reasonable fees charged by a member of a health profession for consulting with a person conducting an examination for the insured person under section 42 (IE), if the conditions of 24.1 (1) are satisfied. <u>Conditions:</u> 1) Consultation is with the medical practitioner who prepared the disability certificate or treatment plan or Form 1 s. 24.1(1)1i s. 24.1(1)1ii s. 24.1(1)1iii 1) The treating medical Practitioner has to agree to the consultation. s. 24.1(1)2 3) Fees cannot exceed the charge for a 30 minute telephone consultation s. 24.1(1)3 **<u>Note:</u>** The treating medical practitioner should ensure they have the consent of their patient to speak to IE doctor	➢ This allows a consultation between the insurer's doctor and one of the injured party's care providers when a s. 42 assessment is done where that person has prepared the disability certificate, the treatment plan, the assessment of attendant care needs or the catastrophic application. ➢ This allows a 30 minutes consultation ➢ Is this an advantage to the insured or the insurer? It is difficult to see how the insured will benefit from allowing the insurer's hired gun to consult with treating health care professionals. Is the purpose of such a consultation to allow the IE doctor to try and influence the treating practitioner to change their mind about the proposed treatment?

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EXAMINATION COSTS **COSTS PAID FOR RESPONDING TO AN IE REPORT** **S. 42.1**		➢ …Reasonable fees for conducting an assessment and a report if: (s. 42.1(3)) - This examination and report is limited to parts of the s.42 IE the insurer disagrees with, and that are relevant to the denial of the claim s. 42.1(3)1 - The assessment is done by the person who approved the treatment plan, Assessment of Attendant Care Needs or Disability Certificate unless the IE done by members of a different health profession	➢ This is allegedly the section that expands the right of the insured person to have a treating provider respond to the IE. It is heavily biased in favour of the insurer. The amounts allowable may be inadequate in may situations, yet there is no limit of what the insurer can pay their expert. The fees that are allowed include transportation, examination and reporting. ➢ The bottom line is that the insurer's right to have the insured examined is dramatically increased while the injured party has to jump through more hoops than ever to get an assessment. ➢ More will be said about section 42 and 42.1 below.

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EXAMINATION COSTS **COSTS PAID FOR RESPONDING TO AN IE REPORT** **S. 42.1**		s. 42.1(5)(a) or not of the same specialty as the IE doctor. s. 42.1(5)(b) or if the IE conducted by two or more health practitioners , then one or more health practitioners who were not the original providers may conduct the examination s. 42.1(6) - If the assessment is for catastrophic determination or person is CAT, report to be sent to insurer within 80 business days, otherwise 40 business days. ➢ Where the s.42 IE is a paper review of the s. 42(10) material provided, and the IE doctor is a member of the same health profession as the original provider, the assessment and report is limited to matters relating to the s. 42 IE.	

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EXAMINATION COSTS **COSTS PAID FOR RESPONDING TO AN IE REPORT** **S. 42.1**		s. 42.1(7) ➢ If a GP or some other health care provider does the examination, the charges are limited to $775. If a physician specialist does the assessment, $900 is the maximum charge (see section 42)	
EXAMINATION COSTS **Immediate Risk of Harm** **s.24(1.2)**	➢ Part 4 of the OCF 22 and s. 24 (1.2)1 permitted an assessment without the need for approval in situations where there was an immediate risk of harm to the person	➢ Insurer approval not required for an assessment or examination for the purposes of preparing a treatment plan where there is an immediate risk of harm to the person or obtaining the insurer's approval is impractical s. 24(1.2)	➢ No change

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NOTICE AND APPLICATION FOR BENEFITS S. 32	➢ Notice within 30 days for accidents prior to October 1, 2003 ➢ Notice within 7 days for accidents after October 1, 2003 ➢ Insurer must notify insured if application is incomplete within 14 days	➢ No Change to notice times ➢ Insurer must notify insured if application is incomplete within **10 business days** s. 32(3.1)	➢ Really no substantial change because of the addition of the words “business days”
FAILURE TO NOTIFY WITHIN 7 DAYS s. 32(6)	➢ Insurer could delay benefits for 45 days after receiving application s. 32(6)	➢ Insurer can delay benefits for the LATER of 45 days after receiving application or 10 business days after the day the person complies with ANY request made by the insurer under s. 33 for information s. 32(6)(a)(b)	➢ Harsher penalty to the insured for failing to give notice within an already very short notice period

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PRE-CLAIM EXAMINATION S. 32.1	➢ No such provision existed	➢ Allows insurer to request an examination of the insured by one or more health professionals of the insurer's choice while insured is still in hospital or long–term care facility or within 3 days of discharge ➢ Exam at insurer's expense ➢ Examination only with insured's consent ➢ Can occur only where no application for benefits has been made ➢ Report from such an exam to be delivered within 5 days to insurer, insured and insured's health practitioner ➢ Any refusal to consent to this examination cannot affect the rights of the insured to benefits ➢ Insurer cannot rely on report to deny a benefit claimed later	➢ What has this section to do with removal of the DAC system ➢ Purely expansion of insurers right to exams ➢ Non-binding on either party ➢ No obligation on insurer to follow report ➢ No representation of insured for this exam ➢ INSURED SHOULD NOT CONSENT TO THIS ➢ Why should this report be sent to insured's health practitioner?

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DUTY OF APPLICANT TO PROVIDE INFORMATION S. 33	➢ Insured to supply any information reasonably required by the insurer within 14 days of the request ➢ -includes statutory declaration, address, proof of identity, and examination under oath if requested	➢ Section 33 is essentially the same requirements except within **10 business days**	➢ No material change despite change from 14 days to 10 business days ➢ Insurer not required to pay benefits for any period during which insured fails to provide requested info or fails to attend examination under oath
SPECIFIED BENEFITS -IRB -NON-EARNER CAREGIVER HOUSEKEEPING & HOME MAINTENANCE s. 35	➢ Each of these benefits had their own section	➢ S. 35 now applies to these weekly benefits **including housekeeping and home maintenance s. 35(1)** ➢ **Insured "shall" submit a completed disability certificate (not older than 10 days prior) with the application s. 35(2)** ➢ **Within 10 business days the insurer must** **i) pay the benefit,** **I) send a request to the insured for information under s. 33 or** **II) request an IE under s. 42** If IE is requested then the IE procedure and time limits under s. 42 kick in	➢ Even if insurer requests information under s. 33, they can request an IE after receiving that information ➢ No obligation on insurer to pay benefits while waiting for disability certificate s. 35(13) or if insured does not attend IE- s. 35(10) ➢ Many built-in ways the insurer can avoid paying the benefit by the combination of s. 33 and s. 42 if the insured does not supply all the information required under those sections and within the tight time limits of those sections ➢ Could result in long delays before benefits are paid ➢ Only penalty for insurer not supplying IE within time periods specified in s. 42 is that insurer has to pay the benefit from 15 days after the IE up to the date the report is delivered. S. 35(14) ➢ Insurer has to pay back withheld benefits if the insured person provides a reasonable explanation for not attending IE, if the insurer determines that the insured person is entitled to the specified benefit—s. 35 (11)b

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ELECTION OF IRB, NON-EARNER OR CAREGIVER BENEFIT s. 36	➢ Insured must select only one of these benefits and insurer must send an election form within **14 days** of receiving application for benefits	➢ No change except insurer must deliver election form **within 10 business days** of receiving application	➢ No material change

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DETERMINATION OF CONTINUING ENTITLEMENT TO SPECIFIED BENEFITS s. 37	➢ S. 37 previously outlined procedure for refusal or stoppage of IRB, Caregiver or Non-Earner Benefit	➢ New section outlines procedure for "Continuing Entitlement to Specified Benefits" ➢ Insurer shall request a new disability certificate to determine if benefit is still payable- s. 37(1)(a) or request insured to attend an IE- s. 37(1)(b) ➢ Insured has 15 days to supply the disability certificate- s. 37(1)(a) ➢ Insurer not to discontinue paying benefit unless the insured fails to submit the new disability certificate s. 37(2)(a) or the insurer receives IE and decides to terminate the benefit no matter what the IE report says s.37(2)(b) or the insured fails to attend IE, or fails to supply necessary information to IE doctors s. 37(2)(c) or other enumerated reasons s. 37(2)(d)(e)(f)If insured who fails to supply information to IE doctor or fails to attend IE and later complies, insurer to repay withheld benefits, if insured provides reasonable explanation within 10 days s. 37(8)(c) If insurer decides to terminate a benefit after IE exam, the insurer cannot stop paying until they have given a copy of the IE and an explanation of the denial to the insured. s. 37(9)	➢ If insured does not submit new disability certificate within 15 days, insurer does not have to pay benefits from the 15th day after the insurer's request up to the time the insured complies- s. 37(3) ➢ Unlike the DAC system, there is no obligation on the insurer to pay the benefit even if the IE supports the payment of the benefit ➢ Again the IE is to be sent to the treating medical practitioner- Why is this necessary?

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PRE-APPROVED FRAMEWORK S. 37.1	➢ PRE-APPROVED FRAMEWORK	➢ PRE-APPROVED FRAMEWORK	➢ See sections for same type of changes replacing DAC with IE's
MEDICAL & REHABILITATION BENEFITS S. 38	➢ Application for assessment existed	➢ Applications for Assessment are submitted with the treatment plans. 38(2) for all med/rehab expenses that are not PAF ➢ Insurer not required to pay for med/rehab benefit without application for the benefit, except for ambulance and emergency goods & services within first 5 days of accident s. 38(1.1) ➢ Application for med/rehab benefit must include: -signature of insured unless waived by insurer-s.38(2) -treatment plan -statement by a health practitioner approving the treatment plan and stating that expenses are reasonable and necessary and not PAF s. 38(2)	➢ Social workers included in list of people who can complete a Treatment Plan

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PRE-APPROVED FRAMEWORK S. 37.1	➢ PRE-APPROVED FRAMEWORK	➢ PRE-APPROVED FRAMEWORK	➢ See sections for same type of changes replacing DAC with IE's
MEDICAL & REHABILITATION BENEFITS S. 38		➢ Contents of Treatment Plan outlined in s.38(3) ➢ Following receipt of Treatment Plan the insurer shall give one of the following notices to the insured: -Disclosing any insurer's conflict of interest -outlines goods/services insurer agrees to pay for -outlines goods/services insurer does not agree to pay for and request s. 42 IE -advises that a good/service falls under PAF guidelines and s. 42 IE required to determine same- s. 38(8) ➢ Notice to be given with 10 business days after insurer receives application for med/rehab expense- s. 38(8.1) ➢ Insurer to pay for the goods/services under a treatment plan from 11th day after receipt of the application up to date of notice	

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MEDICAL/REHAB EXPENSES WHERE INSURER DOES NOT REQUIRE A TREATMENT PLAN S. 38.1	➢ No changes	➢ No changes	
ATTENDANT CARE BENEFITS S.39	➢ 14 days after receiving application insurer must pay or demand Form 1 ➢ Where insurer challenges Form 1 a DAC must occur ➢ Insurer required to pay attendant care benefits pending DAC	➢ New Form 1 has been created ➢ Insured submits and Assessment of Attendant Care Needs from a health professional authorized to treat the impairment- s. 39(1) ➢ Within 10 days insurer must pay attendant care or request s.42 IE- s. 39(2) ➢ Insurer must pay attendant care expenses pending IE, but only where an assessment of attendant care needs has been submitted- s.39(3)(4)	➢ Dramatic increase in the insurer's rights to challenge attendant care expenses whenever they want. ➢ Tight time frames for insured to respond to request for further assessment of attendant care needs ➢ Effect of expanded rights of s. 39 taken with the limited ability of insured's to respond to IE's in s. 42 is a huge benefit to insurers to attack and deny attendant care expenses

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ATTENDANT CARE BENEFITS S.39		➢ Insurer may demand repeated attendant care assessments by requesting a new assessment of attendant care needs, which insured must supply within 10 days of request s. 39(5) and further IE if requested-s. 39(6) ➢ After 104 weeks, insurer can only request s. 42 IE at least 1 year apart- s. 39(10)	➢The harsh timelines of s. 42 requirements on insured to produce documentation to the IE assessor operates as a further penalty to the insured in situations where the injury is likely severe, and it will be difficult for the insured to obtain necessary medical information within the short time periods outlined in s. 42. This can lead to suspension of necessary attendant care benefits to an insured for various time periods
OTHER BENEFITS Death /Funeral Benefits s. 41	➢ Payment within 30 days after receipt of the application for benefits	➢ No change	

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DETERMINATION OF CATASTROPHIC IMAPAIRMENT s. 40	➢ 14 days after receiving an application, the insurer must pay attendant care benefits or demand a Form 1 ➢ If insurer does not agree with Form 1, then an DAC must be arranged ➢ Insurer must pay for attendant care benefits pending the DAC report	➢ A new Form 1 has been produced (see Tab with new Form 1) ➢ Process commenced by delivering and Assessment of Attendant Care Needs completed by a health practitioner authorized to treat the impairment. ➢ Insurer must give notice within 30 days of receipt of application accepting the impairment as CAT or requesting s. 42 IE s. 40(2) ➢ If insured was receiving attendant care benefits before the application is made, and if application is within first 104 weeks, the insurer must continue to pay attendant care benefits until determination is made s. 40(3) ➢ Insurer must provide report of IE within 5 days of the examination- s, 40(4) ➢ Insured has the obligation to provide all necessary medical information under s. 42(10) – s. 40(6)(7) ➢ Same rules apply to the insured and the insurer for failure to comply with s. 42 requirements for medical information-s. 40(7) or for delivery of report- s. 40(8)	➢ The harsh requirements of s. 42(10) requiring the insured to produce necessary medical information to the IE assessor continues to penalize the insured, as this information will be very difficult to obtain within the tight time periods, and benefits may be suspended if information is not provided within 5 days- s. 40(6) ➢ The only penalty to insurer for not supplying report within 5 days of examination is to require them to pay benefits from 15 days after IE doctor receives necessary medical information or 15 days after an examination up to the date the report is delivered- s. 40(8)

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TRANSITIONAL RULES S. 41.1		➢ For claims where notice has been given before November 1, 2005 relating to weekly benefits, told rules apply ➢ The new provisions apply to all accidents, provided that notice of DAC was not already given prior to November 1, 2005	
INSURER EXAMINATIONS S.42 **DUTY TO PROVIDE MEDICAL INFORMATION TO IE ASSESSOR s. 42(10)** **TIME PERIODS FOR DELIVERY OF IE REPORTS s. 42(10) s. 42(11)**		➢ Insurer only needs to give 5 days notice of a proposed exam-(notice can even be verbal if followed by a letter confirming it) ➢ Insurer's can do as many IE's as they wish except in PAF cases ➢ PAF examinations and CAT determination must be paper review only ➢ Insurer has to make "Reasonable Efforts" to scheduled an IE for a time and location convenient to the insurer-within 30 km of insured's house unless they live outside a geographical region defined in the legislation	➢ This is a very short window of notice for an examination ➢ Expanded right of insurer to do examinations. ➢ The 30 km restriction says nothing about IE doctors traveling to do the examination, and therefore there is no practical restriction on the insurer's ability to conduct IE's with whomever they wish ➢ This requirement is unduly harsh on injured parties. There is virtually no way an insured will be able to obtain the necessary medical information and test results (most often in the hands of 3rd parties) within this short time period.

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INSURER EXAMINATIONS **S.42** **DUTY TO PROVIDE MEDICAL INFORMATION TO IE ASSESSOR** **s. 42(10)**		➢ S. 42(10) REQUIRES THE INSURED to provide to the IE assessor within 5 business days of the notice of the appointment "all reasonably available information and documents that are relevant or necessary for a review of the insured person's medical condition", and if an attendance is required at the IE, the insured "shall submit to all physical, psychological, and functional examinations requested by the person or persons conducting the examination" ➢ The IE assessor need not provide a report until s. 42(10) has been complied with. Where no examination of insured required:-exam completed and report delivered within 10 days if exam relates to a person with a CAT injury, and in all other cases within 5 days. s. 42(11)(1)	➢ Why does the insurer not have the responsibility to obtain necessary medical information for an IE exam which they request? ➢ Who decides what is relevant and necessary information for the IE assessor

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TIME PERIODS FOR DELIVERY OF IE REPORTS **s. 42(10)** **s. 42(11)**		➢ If a physical examination is required, the exam must take place within 30 days of compliance with s. 42(10) for CAT injuries and the report is to be delivered 10 days after the examination. s. 42(11)(2) ➢ For Non-CAT injuries, the assessment is within 10 days after compliance with s. 42(10) and the report is to be delivered 10 days after the exam s. 42(11)(3) ➢ The biggest burden is that the Insurer can withhold conducting the examination until s. 42(10) has been complied with, (s. 42(12)) and each of the benefit sections permit withholding of benefits if the insured does not comply with s. 42(10) without explanation	➢ This will lead to potentially long delays in the IE being conducted, and delays in the insured receiving benefits

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ASSESSMENT OR EXAMINATION AFTER DENIAL OF BENEFIT **S. 42.1**		➢ Original Provider" is the member of a health profession who approved the original Treatment Plan, Form 1, Disability Certificate or CAT Application under s. 40s. 42.1(1) <u>If Insured Attended IE and Report Provided to insured s.42.1(2)</u> Where benefit denied or insurer denies that a person is CAT after attending IE, and the exam was; -not related to PAF ancillary goods and services s. 42.1(2)3i -not application for an assessment under s. 38.2 s. 42.1(2)3ii -not an exam to determine if PAF applies s.42.1(2)4 -not an exam under s. 42 related to a specified benefit (ie s. 35 weekly benefit or housekeeping benefit) and no assessment or exam has previously taken place s. 42.1(2)5 -not an exam related to attendant care benefits under s. 39 and no assessment or exam has been conducted within last year	➢ The conditions are numerous and cumbersome

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ASSESSMENT OR EXAMINATION AFTER DENIAL OF BENEFIT **S. 42.1** **Continued**		s. 42.1(2)6 If the above conditions are met, and the further conditions below are met, then the **insurer may have to pay these limited fees to respond to the IE:** -Non-CAT cases- $450 for review of material only -For examination and report $775 for non-specialist (ie family doctor) -$900 for specialist s.42.1(3)8 ➢ **Further conditions** must be complied with in order for insurer to be required to pay these fees: **s. 42.1(3)** 1) Where IE has been sent to the insured, the response can only address those portions of IE which insured person disagrees with and which are relevant to denial of the claim s. 42.1(3)1 2) The person conducting the responding examination must be a member of a health professional authorized under this section to conduct the exam	➢ Practically speaking the insured will not be able to get more than one responding report for the maximum of $900.00. Many specialists will not even respond for that amount. Secondly, where multiple reports are necessary, the $900.00 limit still applies. The insured is therefore at the mercy of the insurer who can conduct unlimited IE's with no cost restrictions. ➢ The further conditions of s. 42.1(3) are cumbersome and hard to follow. There appear to be no comparable obstacles for the insurer

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ASSESSMENT OR EXAMINATION AFTER DENIAL OF BENEFIT **S. 42.1** **Continued**		s. 42.1(3)2 (3) If the injured person CAT or if exam related to whether person was CAT, and the assessment/exam is conducted and report provided to insurer not more than 80 business days after the day the insurer gave the insured notice of its determination s. 42.1(3)3 (4) If insured is not CAT and the exam under s. 42 did not related to whether the person was CAT and the assessment/exam is conducted and report delivered to the insurer not more than 40 business day after the insurer gave notice of its determination s. 42.1(3)4 (5) The responding report to be from the same person who completed the original form unless the IE assessor was from a different health profession or different specialty or the IE was multi-disciplinary	➢ The old legislation matched examinations by type of practitioner, and this appears to have been departed from in this legislation. It appears that due to the $900 maximum cost restriction on responding reports, the insured will be limited to as many responding reports as can be obtained for $900. The practical effect is that the insured may be limited to one responding report, even where the IE is a multi-disciplinary report of several medical practitioners

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ASSESSMENT OR EXAMINATION AFTER DENIAL OF BENEFIT **S. 42.1** **Continued**		➢ Original Provider" is the s. 42.1(4) & s. 42.1(5)(6) (6) The responding review is limited to a review of the same s. 42(10) material the IE assessor reviewed; a) where the IE examiner and the responding person are of the same qualifications, s. 42.1(7)(a) or b) where the original IE exam was limited to a review of only the s. 42(10) material s. 42.1(7)(b) or c) where the assessment relates to a claim for med/rehab benefits and an assessment or exam of the insured with respect to the same accident has been conducted within the previous 12 months s. 42.1(7)(c) ➢ The responding report does not oblige the IE doctor to comply with its findings- s. 42.1(10) and is only to be used "for the purposes of assisting in the resolution of a dispute in accordance with sections 280-283 of the Act.	➢ **The effect of these changes is to create a very complex piece of legislation for the insured to navigate through. Often the insured will not be able to afford a lawyer to assist them in navigating through these rules and tight time periods, and the insured will therefore be at the mercy of the insurer, which has virtually limitless ability to assess the insured**

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ASSESSMENT OR EXAMINATION AFTER DENIAL OF BENEFIT **S. 42.1** **Continued**			➢**The changes to the legislation are a major movement away from the principal under the old legislation that an injured party's treatment should be governed by their treating medical practitioners.** ➢**The extensive powers given to the insurer under s. 42 allow insurers to examine an injured party as often as they wish, with as many IE doctors as they wish, with no financial constraints on their ability to conduct these examinations. Contrast this to the highly constrained and financially restricted ability in the insured to respond to the IE reports.** ➢**The Unfair and Deceptive Practices legislation is unlikely to be sufficient protection for the insured, against multiple insurer examinations.**

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The End!