AMENDMENTS TO THE AUTO INSURANCE REGULATIONS: ACCIDENT BENEFITS AND BILL 198

Introduction

Earlier this year, the Progressive Conservative Government passed Bill 198 amending the Insurance Act. This represents the fourth major revision to the "no-fault" auto insurance scheme since 1990. These amendments had been initiated by the Government in two separate stages.

This paper is intended to identify the changes to the Statutory Accident Benefits Schedule. Further information is provided with respect to the role of different stakeholders within this process in order to provide contextual background for these amendments.

Highlights of the Amendments to the Statutory Accident Benefits Schedule

Stage 1 – Amendments to the Statutory Accident Benefits Schedule

Representatives of the Insurance Bureau of Canada, the legal community and health professionals worked collaboratively in a consensus process to suggest changes to Bill 59 that could achieve cost savings and premium reduction while providing access to benefits for those who are injured in auto accidents. These consensus recommendations were generally reflected in the Bill 198 Regulations introduced July 2003.

1. Section 24 – Medical Assessments

Under the new Regulations, most medical assessments require approval from the insurer. With few exceptions, an injured person will not have the right to obtain medical reports from treating health professionals without the insurer's prior approval. If the insurer does not give this approval, a DAC will be required.

The insurer will have only five days (3 days if the assessment and the report is $180 or less) to approve the initial request for a medical assessment. If the request is denied, a "fast track" DAC will have seven days to perform a paper review and decide whether such an assessment

and report is reasonable. This puts a very heavy onus on the insurer. Not only must they deal with the initial request within five days but they must also set up DACs in a very short period of time. If insurers do not meet these new timelines, they will have to bear responsibility for any delay in treatment.

This will be a retroactive change applying to all Bill 59 motor vehicle accident claims.

It should be noted that psychological assessments completed according to the Psychology Assessment and Treatment Guideline do no require prior approval. The Guideline is to be reviewed by December 31, 2003.

2. Pre-Approved Framework for WAD I and II Injuries (PAF) – Section 37.1

Prior to October 1, 2003, the SABS allowed treatment providers to carry out physiotherapy or chiropractic treatment for the first six weeks (up to 15 sessions) without the prior approval of the insurer. The new regulations outline a complicated system for pre-approved treatment of "simple" WAD I and II cases. If the treating practitioner stays within the guidelines then the care is automatically approved by the insurer. The PAF will only be in effect during the acute phase of treatment (the first six weeks following the accident).

The injured person does not give up any right to reasonable and necessary services after the PAF is completed. However, the insurer is not obligated to consider any additional treatment plans while the person is in the PAF unless the treatment plan is submitted in accordance with the controls built into the PAF. In addition, during the time period when the PAF applies, the insurer may challenge any treatment plan on the basis that the PAF is applicable.

Although much detail has been put into this new section, the PAF will not affect the rights of victims. The PAF was developed through a collaborative process and incorporated evidence about acute treatment of WAD I and II conditions. For those with WAD I or WAD II injuries and who recover within the limited time frame of the PAF, this framework may actually be of benefit to access a program of care without need for insurer approval.

In July 2003, the FSCO issued PAF guidelines. These guidelines are only applicable from October 1 to 31, 2003. From November 1, 2003 onward the amended guidelines issued in September 2003 will be applied (Nov. 6/03).

3. Treatment Plans – Section 38

Treatment Plans now must be signed by the injured person. In addition, the legislation now clearly spells out that if the insurer does not either approve or reject the Treatment Plan within 14 days of receipt, then the Treatment Plan is deemed approved until such time as the insurer responds. This will be a retroactive change applying to all Bill 59 claims.

4. Definition of Catastrophic Impairment – Section 2 (1).1

Under the new definition, health care practitioners will still be required to certify that the insured person's injuries are stable [under subsections (f) and (g)]. The required statement about stability is now more consistent with clinical understanding. However, in the alternative, if two years (instead of three) have passed since the time of the accident, then this requirement will be unnecessary.

As well, there is a new definition for the determination of catastrophic injuries involving children. This will direct health care professionals to take "into consideration the developmental implications of the impairment". This will not be a retroactive change, but only apply to accidents after October 1, 2003.

5. Definition of a Health Care Practitioner – Section 2 (1)

Occupational therapists, registered nurses with extended certification and speech/language pathologists will now be considered practitioners. Therefore, these individuals may certify disability and sign Treatment Plans. This will be a retroactive change applying to all Bill 59 claims.

6. Deadline for the Initial Application for Accident Benefits – Section 32 (1)

Insured persons will be required to file their Application for Accident Benefits within seven days of the accident. This is a change from the previous legislation which allowed the application to be submitted within 30 days of the accident.

7. Examinations Under Oath – Section 33

In order to "combat fraud", the insurer will be permitted to examine the insured under oath for the purpose of determining whether or not they are entitled to statutory accident benefits.

8. Procedure for Continuation of Income Replacement Benefits Following Denial by the Insurer – Section 37

Under Bill 59 Regulations, if the insurer denies income replacement benefits, the applicant has 14 days to request the DAC. If a DAC is requested, then the injured party continues to receive income replacement benefits until such time as the DAC is completed. As many of us know, this process often takes several months. However, under the new legislation, the injured person will not only have to request the DAC within 14 days, but will also have to provide a new updated Disability Certificate. This may impose a very heavy burden on the injured person as well as the primary health care practitioner. This will be particularly challenging in communities where there is a shortage of family physicians.

Also note that if the DAC does not find the injured person disabled, then he/she will have to repay the insurer all income replacement benefits paid from the date of cut off to the date of termination of benefits following the DAC.

9. Insurer Examinations (Section 42 (1)

The insurer will not be permitted to perform medicals in relation to a PAF or medical and rehabilitation benefits (under Sections 14 and 15) until after the DAC is completed. In addition, the insurer will only be allowed to perform medicals for benefits for which the an application is made. Any

Section 24 insurer examinations conducted under the direction of the insurer must be conducted under these provisions.

Stage 2: Additional Changes to the Implementation of the Statutory Accident Benefits Schedule

Additional changes were announced that impact the implementation of accident benefits. These additional changes were not part of the consensus process.

1. Choice of DAC (Ont. Reg. 313/03)

Previously, under Bill 59, the DAC selected to perform an assessment would simply be that which was closest to the injured person's home.

Now, the insurer and the insured person can "mutually select" any DAC within a 50 kilometre (30 kilometre in the GTA) radius of the injured person's home to perform the assessment. The process for this "joint" decision making is not specified and it is anticipated that the insured will often select a DAC or a list of DACs to present to the insured person. The injured person only has two days from receiving notice of this request in order to dispute the insurer's choice of DAC. If such a dispute is lodged, than the Financial Services Commission will choose the DAC. It is understood that the FSCO selection process will be on a randomized basis and will not necessarily be the closest DAC to the person's residence. There is no ability to dispute the choice made by the Financial Services Commission of Ontario.

For right or for wrong, many people already perceive that the DAC system is not impartial. Unfortunately, it is feared that this regulatory change will only increase the perception that DAC facilities are bias despite the best efforts of facilities to the contrary. It is most disheartening to think that those honest assessors attempting to perform a service may be tarred with such an unfair characterization. However, as with past legislative changes, the intended effects are always difficult to predict and remedy.

The change to the DAC system is implemented as of October 1, 2003. However, this system will apply to all motor vehicle accidents from November 1, 1996 onward.

2. Professional Services Guideline – Superintendent Guideline 05/03 – September 18, 2003

The Financial Services Commission of Ontario has issued a new guideline outlining the fees the insurer is obligated to pay for medical and rehabilitation treatment under the *Statutory Accident Benefits Schedule* as per the chart below:

Maximum Fees

Automobile insurers are not liable to pay for expenses related to professional services rendered to an insured person that exceed the following maximum hourly rates:

Health Profession or Provider Maximum Hourly Rate
Chiropractors $95.00
Massage Therapists $49.00
Occupational Therapists $84.00
Physiotherapists $84.00
Podiatrists $84.00
Psychologists (other than Master's level) $126.00
Masters of Psychology $93.00
Speech Language Pathologists $94.50
Registered Nurses, Registered Practical Nurses and Nurse Practitioners $77.00
Unregulated Providers $49.00

These maximums that insurers are obligated to pay represent at 30-60% reduction in payments. Interestingly enough, it appears as though social workers are not covered by the new provisions. Thus they are free to charge fees in accordance with the typical provisions of their professional body. Physician's fees are also not limited. Unfortunately, these fee restrictions will place a heavy and most unfair burden on treatment providers.

Insurer payment maximums that are below the level required for viable professional practice will cause treatment professionals to withdraw from this area of practice. In many disciplines, health professionals have a variety of employment options including salaried positions that provide many benefits and do not require the entrepreneurial risk of private practice. The new drastically reduced fee maximums that insurers are required to pay, are a strong disincentive to health professionals to provide

these services which require a high level of expertise. Thus, the reduction in the insurer's obligation to pay for services will result in difficulties with respect to the patient's ability to access these services. However, the changes do not affect the prices which can be charged for medical-legal work.

These changes are effective November 1, 2003 for all accidents from November 1, 1996 onward. For those treatment providers who have treatment plans that are approved before September 18, 2003 which include services to be provided after November 1, 2003, it is understood that the approved treatment plan is a "contract" wherein the provider has agreed to provide a specific set of services for a specific price and the insurer has committed to pay that price. However, after September 18, 2003, any treatment plans submitted will only require insurers to pay the new reduced maximums for services provided after November 1, 2003.

In addition to regulating the fee chargeable for medical and rehabilitation treatment, the Financial Services has also outlined the payment to be given to health care professionals for filing out certain forms as follows:

Fees for Completion of Forms

Automobile insurers are not liable to pay expenses that exceed the following maximum fees for the completion for certain accident benefit forms by members of the health professions and health care providers listed in this Guideline, (These maximum fees do not apply to the assessments related to the completion of these forms).

Maximum Fee for Completion of Forms

Disability Certificate (OCF-3) $62
Treatment Plan Form (OCF-18) $62
Assessment of Attendant Care Needs (Form 1) $62
Automobile Insurance Standard Invoice (OCF-21) $0
Application for Approval of an Examination (OCF-22/198) $0

Please note that physicians and social workers will, once again, not be subject to these fee guidelines. However, for the remainder of health care professionals, these fees will apply.

The fee of $0 for completion of the Application for Approval of an Examination (OCF 22) is particularly striking. Before pursuing most Section 24 medical assessments, an OCF 22 must be filed out by the health care provider. Unfortunately, the professional services guideline has not permitted any fee for filing out this form. However, it should be noted that the maximums noted in the above chart are only applicable for filing out the form. Quite specifically, the professional services guideline indicates that these maximum fees do not apply to the assessment related to the completion of these forms. Thus, it is anticipated and only reasonable that insurers will be forced to pay reasonable fees for the screening examination or initial stage of the assessment that was done by health care providers in order to fill out any of the above-noted forms.

Fees with respect to these forms are effective as of November 1, 2003 for all motor vehicle accidents from November 1, 1996 onward.

3. Income Replacement Benefits

At present, injured persons who are unable to perform their pre-accident employment, can obtain income replacement benefits at 80% of their net pre-accident income up to a maximum of $400 per week. The Government has now implemented an amendment to the *Statutory Accident Benefits Schedule* which will decrease the maximum income replacement benefits to $300 per week. Thus, injured persons with an income of greater than $25,000 per year will not receive an income replacement benefit reflective of their pre-accident income. Quite clearly, this will force many injured victims to return to their employment sooner than they otherwise should in order to avoid financial disaster.

This amendment is effective for policy's renewed after January 1, 2004.

Conclusion

The cost reduction changes to the legislation at first blush appear to levy an unreasonable burden on the insured person and health professional. But, by also adding further bureaucratic requirements and tight timelines to the adjusting of accident benefit files (timelines tighter than those which are currently in place) it is anticipated that insurers will be unable to meet the new expectations. Thus their duty to act in good faith WILL be called into question. It appears that some of the cost remedies

brought in by the previous Government were excessively broad and imposed burdens on all parties, rather than selectively targeting either specific areas of cost drivers or specific situations that generate system costs through fraud and abuse.