Brain Injury Association of Niagara Conference 2006

O. Reg. 546/05
DEALING WITH INSURERS IN A POST-DAC WORLD

WHAT THE PAST 240 DAYS HAVE TAUGHT US

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"HERE WE GO AGAIN"

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"WHERE ARE WE NOW?"

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Ontario Regulation 546/05

Statutory Accident Benefit Amendments

Effective March 1, 2006

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KEY CHANGES

- DACs eliminated
- I.E.s enhanced & Responding Reports facilitated
- Pre Claim Examinations added
- Attendant Care tinkered with
- Non-attendance at I.E. no longer a bar to mediation
- UDAP's expanded

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DACs Eliminated as of March 1, 2006

- Unless DAC was already in progress, scheduled or requested prior to March 1, 2006

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DACs replaced with:

- Insured still continues to submit a claim for benefits in the old manner
- The insured's entitled upon receipt of the benefit application to require a medical or health care examination by an expert of its choice and then make a decision on payment
- No limit on what insurer pays its expert

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DACs replaced with:

- The insurer examination must be completed within the timeframes set out in the regulation
- Insurer must provide a copy of its medical examination report to its insured and the insured's health care provider

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DACs replaced with:

- If a benefit is denied by the insurer after its medical examination and receipt of the report, the insured is entitled to a medical examination and report by a health care provider/professional at the insured's expense
- The insurer then reconsiders its denial in light of the rebuttal report

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Then What?

- If an insured wishes to dispute a denial the insured must:

  i. Mediate at FSCO first;

  ii. Arbitrate at FSCO or litigate in the courts

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Pre Claim Examinations Added to SABs

- If insured is in hospital or long term care facility, or discharged within the previous three days, the insurer may examine (by one or more persons) the insured to determine benefit entitlement

IF

Insured consents (Failure to consent cannot effect entitlement to benefits)

AND

A report arising from the examination shall not be relied on by an insurer to deny a benefit

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Changes to Attendant Care

- New Form 1 effective March 1, 2006
- New Rates:

	Old Rate	New Rate
Routine Personal Care:	**$10.53**	**$11.23**
Basic Supervisory Functions	**$7.00**	**$7.75**
Complex Care	**$16.86**	**$17.98**
Ontario Minimum Wage	**$7.75**	

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Changes to Attendant Care

- Insurer must pay Attendant Care pursuant to Form 1 submitted pending receipt of I.E. Attendant Care Report
- Attendant Care Benefits at the Catastrophic Rate will be paid past two years for a claimant not yet declared or accepted as catastrophic IF the CAT application was submitted before the two year mark until the insurer denies the catastrophic status
- Post 104 weeks – Insurers can demand only one s.42 I.E. per year

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Non-Attendance at Insurer Examination

- No longer a bar to filing for mediation
- Still a basis for an insurer to cease paying benefits

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Amendments to Unfair or Deceptive Acts or Practices

The penalty

Sections 447(2)(d) and 447(3) of the *Insurance Act* provide for a maximum 1st offence fine of not more than $100,000.00 and not more than $200,000.00 on each subsequent conviction.

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Addition to Unfair or Deceptive Acts

- Sending an insured for an examination not reasonably required
- Sending an insured for an examination to an unqualified individual
- Failure to pay without reasonable cause, a claim within the time set out in the SABS

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And Now……The Rest of the Story or “The Devil Is In the Details”

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Insurer Examinations

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- “As often as reasonably necessary”
- Insurer and insured must provide to the insurer’s examiner all reasonably available information and documents that are relevant or necessary within 5 days after notice of examination given
- The insured, not the insurer, must comply with the 5 day requirement. If the insured doesn’t, all times lines postponed

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Insurer Examinations

- Once all documents received, the examination must take place, and report be completed, within 10 days if a CAT determination, otherwise 5 days, if no attendance of insured required
- If attendance required, the report must be delivered within 40 days of notice of examination being received if a CAT determination, otherwise 20 days

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Insured's Responding Examination Report

- The examination and report must be limited to the portions of the insurer's report the insured does not agree with
- The report must be delivered to the insurer within 80 days of the insurer's denial if it is a CAT opinion report; otherwise 40 days
- Who can do the report is restricted

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Insured's Responding Examination Report – Fees:

Non CAT Cases:

- If simply a paper review $450.00
- Health professional (but not a physician) $775.00
- Physician $900.00

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CAT Cases:

- "Reasonable fees and expenses"

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Insurance Act – Part 18 – Unfair and Deceptive Acts and Practices in the Business of Insurance

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439. Prohibition – No person shall engage in any unfair or deceptive act or practice.

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Insurance Act – Part 18 – Unfair and Deceptive Acts and Practices in the Business of Insurance

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447 (2) Every person is guilty of an offence who:

d) Contravenes this act or the regulation.

447 (3) On conviction for an offence under this act, the person convicted is liable on a first conviction to a fine of not more tan $100,000.00 and on each subsequent conviction, to a fine of not more than $200,000.00.

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(1) For the purposes of the definition of "unfair or deceptive act or practice" in Section 438 of the Act, each of the following actions is prescribed as an unfair or deceptive act or practice.

(9) Any conduct resulting in unreasonable delay in, or resistance to, the fair adjustment and settlement of claims

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(5) For the purposes of the definition of "unfair or deceptive acts or practices" in Section 438 of the Act, each of the following actions, if done on or after March 1, 2006, is prescribed as an unfair or deceptive act or practice in relation to a claim for statutory accident benefits under the Statutory Accident Benefit Schedule – accidents on or after November 1, 1996.

(1) The failure or refusal of an insurer without reasonable cause to pay a claim for goods or services or for the costs of an assessment within the time prescribed for payment in the schedule.

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(5) (2) The determination by an insurer that a person is not entitled to a statutory accident benefit or that a person does not have catastrophic impairment if,

(i) The failure or refusal of an insurer without reasonable cause to pay a claim for goods or services or for the costs of an assessment within the time prescribed for payment in the schedule.

(ii) The schedule does not authorize the insurer to make the determination without having obtained the report.

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WHAT SHOULD WE BE DOING?

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Place the insurer and the Financial Services Commission of Ontario Ombudsman on notice of the deceptive act.

(See Appendix "A")

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BE THE FIRST

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- Section 42 allows an insurer to choose its experts to determine benefits payable unless the insured first does a Section 38 request for assessment first for such items as:
    - Attendant Care
    - CAT Status
    - Med/Rehab Benefits
- It is very hard for an insurer to turn down a request for an assessment and then say they need a Section 42 expert of their choosing to determine if any benefit is payable.
- This would be an unfair and deceptive practice. (See Appendix "B")

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Other Difficulties We have Seen

- The insurers never give any consideration or thought to the short notice they are providing insured's. You can insist they be postponed. The insurers appear to be agreeing

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Insurers are not understanding they cannot say "we deny the benefit" and then send the insured to a Section 42 examination – this is an unfair and deceptive act.

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Ensure the Necessary Documents are Sent to Any 42 Examination

- Insurers are not very good at forwarding relevant materials supporting their insured's needs to the 42 examiners

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Frequency

Many insurers are now requiring 42's to be conducted on almost every single benefit claim. This has the effect of wearing the insured down as they are constantly being sent to medical examinations. Such an approach is not reasonable and any time an insurer requests a 42 examination for an ongoing benefit, reference must be made to previous 42 examinations and their findings.

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Mistakes – The 42 Examinations are Tending to be Quick and Very often; Incorrect

Insurers are not using proper experts or enough different experts from various fields for multi-faceted injuries.

What Can We Do?

1. File for mediation right away.
2. Interim Benefit Motion.
   Keyes v. Personal Insurance Co. of Canada [2006] O.F.S.C.D. No. 123

   (See Appendix "C")

Bad Faith Actions

See *Worthman v. AssessMed Inc. (2006) A.D.O.R. (3rd)249*

(See Appendix "D")

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THANK YOU!

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