

BILL 59 – EIGHTEEN MONTHS LATER

Eric K. Grossman and Ryan M. Naimark

INTRODUCTION

At first blush, there is a perception that Bill 59 is a boon for insurers, with a decrease in pendings, a decrease in claim costs and a decrease in both tort and accident benefit exposure – both in terms of volume, and in terms of disputes. However, it is believed this an ephemeral phenomenon which reflects changes made to the prior accident benefit schemes. With the passing of time, the current trend will reverse itself and the loss costs under Bill 59 will likely either be commensurate with or transcend the costs under the other two previous regimes.

In terms of accident benefits, the elimination of non-earners from the system for the first 26 weeks of the disability under subsection 12(7) of the Bill 59 *Schedule*, has had a profound impact on the number of applications filed for mediation and arbitration. However, once the six-month elimination period elapses for the insured person who suffers a complete inability to carry on a normal as a result of an accident, the number of applications will likely rise. It is believe that this increase will also be a short term situation, and that the long term effect will be a permanent drop off in non earner benefit claims. At this time, the six month deductible is not dissuading many from pursuing weekly benefits. However, once the judicial and arbitral effect is given to the very strict entitlement wording, non earners will not actively pursue weekly benefits, except in rare cases.

In tort, the verbal threshold, as seen under Bill 164, will likely continue to be watered down by judicial authority, such that it will become, if it already has not become, virtually non existent. The monetary threshold will dissuade only the most modest of injured persons from seeking to recover in tort. With the advent of the Simplified Rules, mandatory ADR and case management, the costs of litigation will drop sufficiently such that many conservative minded plaintiffs and their counsel will increasingly see the benefit of commencing actions in tort.

The interface between first party and third party claims under Bill 59 will likely also give rise to a sudden surge in applications for mediation, and thereafter, litigation claims, in the immediate future That is because under section 258.3(1)(a) of the *Insurance Act*, the plaintiff must apply for statutory accident benefits prior to commencing and action for loss or damage from bodily injury or death. However, the two-year limitation period for commencing a tort action under the *Highway Traffic Act* will only begin to elapse on November 1, 1998 with respect to Bill 59 cases. Therefore, as plaintiffs scurry to commence tort actions prior to the expiry of the limitation period, the number of applications for mediation on unpaid accident benefits will proliferate as well.

Although only time will decisively determine whether the current reduction in applications are more apparent than real, approximately 18 months have passed since Bill 59 has been implemented. The following pages of this paper will delve into the “nuts and bolts” of various substantive and procedural aspects of Bill 59 as well as comment on the impact and ramifications of those devices where appropriate.

SUBSTANTIVE CHANGES TO BILL 59

Accident Benefits: What Is a “Complete Inability” Under Bill 59?

The phrase “complete inability” is used with respect to income replacement benefits under part II of the *Schedule*, with respect to non-earner benefits under Part III of the *Schedule* as well as with respect to caregiver benefits under Part IV of the *Schedule*. It is notable, however, that in the case of non-earner benefits, this test is applicable from the outset of a claim, whereas it only begins to apply in the case of income replacement benefits and caregiver benefits after 104 weeks.

Section 2(4) of the *Schedule* states that a person suffers a complete inability to carry on a normal life as a result of an accident if, and only if, as a result of the accident, the person sustains an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident.

Although currently there are no decisions dealing with the meaning of “complete inability” in the realm of Bill 59, it is instructive to begin the examination of cases which considered similar entitlement test wording under the other two regimes.

Bill 68

The cases decided under the OMPP regime are very relevant for consideration, notwithstanding that section 13(8)(b) requires that a person is “continuously” prevented from engaging in their normal pre-accident activities, rather than a determination that they suffer a “complete inability” that precludes them from doing so. Although the two provisions are similar, it is probable that the test under Bill 59 will invite more exacting scrutiny.

The strictness of the test under OMPP is reflected in the first decision which considered section 13(8)(b): *Crouter v. Economical*. The Applicant was injured in a car accident on July 3, 1990. She was a 33 year old mother with four children, ranging in age from one to eight. Arbitrator Draper, as he then was, noted that section 13(8) requires a person to be disabled from performing substantially all of his or her “activities”, rather than being unable to perform his or her “essential tasks”, as is the case under section 13(1).

Arbitrator Draper reasoned that this indicated that the test under section 13(8) is a broader test. He went on to decide that on the facts Mrs. Crouter had failed to establish that her primary disability, carpal tunnel syndrome, actually related to the accident. As such, she was not entitled to further benefits under section 13.

Section 13(8)(b) was again considered in *Ms. G. v. Allstate*. The Applicant was injured in a car accident on July 3, 1991. After three years, the Insurer contended that she was no longer entitled to ongoing benefits, suggesting that many of her limitations were caused by earlier physical, emotional and sexual abuse, as well as a 1985 car accident. The Arbitrator rejected these contentions, finding that the Applicant was continuously disabled from engaging in substantially all of her activities. Arbitrator Young held that even though the Applicant had attempted to engage in a number of activities, such as bowling and dancing, the attempts did not constitute “engaging in” the activities. Arbitrator Young held that even if the test under section 13(5)(b) should not be viewed qualitatively (i.e. by focussing on the enjoyment of her lifestyle and the activities she could undertake), the test was nevertheless a practical one. If the Applicant could not engage in activities from a practical standpoint, as was the case here, this was sufficient to support ongoing entitlement.

In *Roberta Urquhart v. Zurich Insurance Company* the OIC once again had occasion to consider the section 13(8)(b) test. The Applicant, a 22-year-old woman, was injured in a motor vehicle accident on November 6, 1992. The Applicant had been an unpaid homemaker for the two years preceding the accident. The accident badly fractured the Applicant’s left femur in the area of the trochanter. The Insurer paid the Applicant a weekly benefit of \$185.00 plus \$50.00 for each of her three children. The Insurer terminated these benefits on the third anniversary of the accident.

The Applicant testified that she could no longer stand for more than 5 minutes, that sitting for anything beyond 10 minutes caused her pain to increase and that she could not lift or carry even light objects because of pain and poor balance. After considering the testimony of the Applicant and the medical evidence, Arbitrator McMahon found that the Applicant’s gait was afflicted by the accident and this seriously hindered her mobility. Moreover, she had experienced a loss of strength in her abductor muscles. She continued to suffer from significant pain and her pain had worsened in the last year.

Two years after her accident, the Applicant’s counsel retained an expert to prepare a functional capacity evaluation rehabilitation report. The occupational therapist who was responsible for evaluating the Applicant gave evidence that the Applicant frequently employed improper and unsafe body mechanics when completing household chores. These poor mechanics impaired the Applicant’s ability to do house cleaning and to prepare meals. She further testified that the Applicant tired easily even with relatively light tasks and that as she tired her pain behaviours became more prominent. She concluded that the Applicant was incapable of meeting her homemaker and child care responsibilities. Arbitrator McMahon relied on the report’s detailed analysis of the

Applicant's abilities within her own home.

He noted that section 13(8)(b) stipulates that a benefit is payable only if the disability extends to substantially all of the person's activities. Relying on the decision in *Ms. G. v. Allstate*, Arbitrator McMahon determined that the words "engaging in" in sub-section 13(8)(b) suggest a qualitative analysis of the activity as a whole is necessary. Where an individual's ability to carry out an activity is changed markedly and the character of the activity is not comparable, it cannot be said the person is "engaging in" the activity. An arbitrator may be justified in concluding that a person is unable to engage in an activity if the length of time that it takes the individual to complete a task becomes extreme. As well, if the degree to which an individual can participate in an activity is sufficiently restricted, the individual can also be found to be no longer "engaging in" the activity. Arbitrator McMahon noted that section 13(8)(b) benefits may only be awarded to people who are *prevented* from engaging in an activity. The Arbitrator reasoned that the phrase "prevented from engaging in" represented a higher degree of disability than "substantial inability", which is required in section 13(1) of the *Schedule*.

Applying this reasoning, Arbitrator McMahon held that the Applicant was not entitled to an award of weekly benefits under section 13(8)(b). The Applicant was able to engage in many of the household chores which were to be accomplished daily. The evidence of the Applicant's expert indicated that with the appropriate level of assistance, the Applicant would be able to manage her daily affairs. Although the Arbitrator found that the Applicant suffered from a substantial inability to engage in many of her household chores, he was not satisfied on a balance of probabilities that the Applicant's disability was so pervasive that it prevented her from engaging in substantially all of her homemaking activities.

It is unfortunate that there has been so little consideration of section 13(8)(b) of the OMPP *Schedule*. However, the Arbitrators who have given the provision any consideration have concluded that it is a broad test but that it is not necessary to demonstrate a complete inability to attempt a former activity; rather, an insured person must demonstrate either from a practical perspective or on the basis of a qualitative analysis that he or she cannot engage in substantially all of his or her pre-accident activities. Thus, although Arbitrator Young in *Ms. G v. Allstate* suggested that it is not appropriate to engage in a qualitative analysis, he appeared to be using the term "qualitative" in a somewhat different manner than was the case in *Roberta Urquhart v. Zurich*, where Arbitrator McMahon actually relied on the *Ms. G v. Allstate* decision in finding that an arbitrator should engage in a qualitative analysis. In essence, both decisions seem to agree that while a mere impact on an individual's enjoyment of life is not the proper subject of inquiry, nevertheless the fact that an individual is capable of engaging in any aspect of an activity does not preclude that individual from meeting the test set out in section 13(8)(b) of the *Schedule*. That being said, the test for entitlement to such benefits remains very high indeed and this is no doubt the reason that there has been so little arbitral or judicial consideration of the rather stringent test: very simply,

notwithstanding minor ambiguities, it remains quite clear that an insured person must be significantly disabled indeed in order to ever qualify for such a benefit.

Bill 164 And Beyond

Although the Bill 164 *Schedule* is structured differently than the OMPP *Schedule*, so that at first glance the test appears to be distinctive which applies to entitlement to “no-income” benefits, this appearance is more ephemeral than real. Thus, section 19(7) of the Bill 164 *Schedule* provides that an insured person only continues to be entitled to further other disability benefits after 104 weeks where that person can demonstrate that he or she “is suffering a complete inability to carry on a normal life as a result of the accident”. The phrase “complete inability to carry on a normal life” is defined in section 3 of the *Schedule*. This section states that a complete inability to carry on a normal life occurs when “an impairment continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident.” As such, the only difference is that the test in section 13(8)(b) of the OMPP *Schedule* refers to the “activities in which the person would normally engage” rather than the “activities in which the person ordinarily engaged”. It is fair to suggest that this distinction is likely to be viewed as trivial in nature.

In *J.p. v. Wawanesa Mutual Insurance Company* the OIC recently had occasion to consider this test in the context of Bill 164. This case makes it clear that section 19(7) will be given a reading similar to that which was given to section 13(8)(b) under the Bill 68 *Schedule* – but also highlights the dangers inherent in the pursuit of long term non-earner benefits. In this case, the 16 year old Applicant was injured in a motor vehicle accident on March 10, 1994. She applied for “other disability benefits” pursuant to section 19(7) of the *Schedule*. The Insurer terminated benefits on March 10, 1996 on the basis that the Applicant did not suffer a complete inability to carry on a normal life.

The Applicant was riding on a bicycle when she was struck by a motor vehicle. She suffered devastating injuries to her head, right shoulder, right arm, pelvis, right thigh and foot. She suffered very significant brain injuries. As well, she lost all flexion of her right arm and in practical terms all use of that arm. She also suffered a limited speech defect. The Arbitrator noted that at the time of the accident the Applicant was not in school nor had she been working.

Arbitrator Jones noted that a person suffers a complete inability to carry on a normal life if that person suffers an impairment that continuously prevents him or her from engaging in substantially all of the activities in which he or she ordinarily engaged before the accident. As such, in order to determine if the Applicant met this test, it was necessary to examine her pre-accident activities and then determine to what extent she could perform these activities 104 weeks after the accident.

Arbitrator Jones reasoned that when considering what activities the Applicant was engaged in before the accident, it was not appropriate to simply take a “snap shot” of her activities on the day or week before the accident. Rather, it was necessary for her activities to be assessed over a reasonable time period. Upon reviewing the documentary evidence and the testimony of the Applicant, Arbitrator Jones found that the Applicant’s relevant pre-accident activities included: watching television, meeting with friends, taking walks, bicycling, personal care, occasional caring for children, and very occasional unskilled and unpaid labour. The Arbitrator then reviewed in some detail how the Applicant’s activities had changed post-accident.

Arbitrator Jones noted that one of the many difficulties in this case was that the Applicant was able to do some of the activities that she did before the accident but not to the same extent as she had been able to engage in such activities prior to the accident. “Going through the motions” did not in the Arbitrator’s view constitute what a reasonable person would define as “engaging in” the activities. Therefore, Arbitrator Jones held that the test of eligibility contemplated by the *Schedule* is more than a simple exercise of comparing what was done previously and what is being attempted today. While it is not necessary that an Applicant resume activities to the same extent as those undertaken prior to an accident, he or she must have at least recovered to a level where there is some reasonable comparison between the pre- and post-accident activities.

Counsel for the Applicant submitted that it is not appropriate to simply look at the activities of an insured person in the period prior to an accident. This would be unfair to someone like the Applicant who was only 16 years of age at that time. Her daily activities would change as she grew older. As such, the suggestion was made that the test must in some way contemplate the activities that the Applicant would have reasonably been expected to do in the future, but for the accident. However, in rejecting this position, the Arbitrator held that the wording of section 3 was very clear. Accordingly, in applying the facts of the case to the test set out in section 3, he was restricted to looking at only those activities performed prior to the accident. After considering all the testimony and reviewing the documentary evidence, the Arbitrator reluctantly concluded that the Applicant had not suffered an impairment that continuously prevented her from engaging in substantially all the activities in which she ordinarily engaged before the accident.

On balance, it is fair to suggest that the result in *J.p. v. Wawanesa* is essentially what one would have expected under section 13(8)(b) of the Bill 68 *Schedule* and therefore that the decision serves to confirm that the earlier authority continues to hold predictive value, if nothing else, when one is considering the effect of the “complete inability” test in any given fact situation.

Indeed, as the “complete inability” test in Bill 164 is the very same test which is used under Bill 59, it is also clear that the foregoing arbitral authority will continue to hold sway in the non-earner context under this most recent regime.

TORT: BILL 59 AND THE ERODING THRESHOLD

The Verbal Threshold

For analytical purposes, it is useful to set out the wording of the threshold under the three regimes:

1. OMPP (June 22, 1990 to January 1, 1994)

“In respect of loss or damage arising directly or indirectly from the use or operation, after the 21st day of June, 1990, of an automobile and despite any other Act, none of the owner of an automobile, the occupants of an automobile or any person present at the incident are liable in an action in Ontario for loss or damage from bodily injury arising from such use or operation in Canada, the United States of America or any other jurisdiction designated in the *Statutory Accident Benefits Schedule* involving the automobile unless, as a result of such use or operation, the injured person has died or has sustained,

(a) **permanent serious** disfigurement;

(b) **permanent serious** impairment of an important bodily function caused by continuing injury which is **physical** in nature.”

2. Bill 164 (January 1, 1994 to October 31, 1996)

(1) Despite any other Act and subject to subsections (2) and (6), the owner of an automobile, the occupants of an automobile and any person present at the incident are not liable in a proceeding in Ontario for loss or damage from bodily injury or death arising directly or indirectly from the use or operation of the automobile in Canada, the United States of America or any other country designated in the *Statutory Accident Benefits Schedule*.

(2) Subsection (1) does not relieve a person from liability for damages for non-pecuniary loss, including damages for non-pecuniary loss under clause 61(2)(3) of the *Family Law Act*, if as a result of the use or operation of the automobile the injured person has died or has sustained,

(a) **serious** disfigurement; or

(b) **serious** impairment of an important **physical, mental or psychological function**.

3. Bill 59 (November 1, 1996 forward)

Despite any other Act and subject to subsection (6), the owner of an automobile, the occupants of an automobile and any person present at the incident are not liable in an action in Ontario for Damages for non-pecuniary loss, including damages for non-pecuniary loss under clause 61(2)(e) of the *Family Law Act*, from bodily injury or death arising directly or indirectly from the use or operation of the automobile, unless as a result of the use or operation of the automobile the injured person has died or has sustained,

- (a) **permanent serious** disfigurement; or
- (b) **permanent serious** impairment of an important **physical, mental or psychological** function.

The main concepts overall, are that the injury be “serious”, “permanent” or “physical in nature”. Of the three thresholds, the OMPP threshold is the strictest as it requires an injury to be serious, permanent and physical. The Bill 164 threshold is the most lenient as it only requires that the injury be serious. The Bill 59 threshold lies somewhere in the middle as it requires that the injury be both serious and permanent.

Since common language is used through the three thresholds, the case law is transferable from one regime to the next. For example, the cases from OMPP that deal with what injuries are “serious” are relevant to Bill 59 cases. Similarly, OMPP case law with respect to the issue of whether or not an injury is “permanent” has application to Bill 59. On the other hand, any OMPP cases which delve into the issue of whether or not the person has “continuing injury which is physical in nature” would not have application for Bill 59 claims.

The following is a review of the salient provisions of the Bill 59 threshold:

Permanent Impairment

Permanent means indefinite. There have been no significant decisions bearing upon this issue.

Serious

The most contentious issue in threshold litigation is that of seriousness. There have been several recent significant decisions relative to this issue.

Meyer v. Bright always serves as a starting point for a consideration for any threshold analysis. In that case, the Court of Appeal made the following observations:

1. “Serious” relates to impairment and not to injury;
2. There is no justification in the statute for interpreting “serious” as significant or as approaching the catastrophic;
3. The task of the Court in each case will be to decide whether the impairment is “serious” to the particular injured person who is before the Court;
4. Even if the financial impact upon the plaintiff is not substantial, the frustration of an injured person’s career path generally should be considered a “serious” matter.

The Court made two crucial statements in different parts of the judgment which serves as a commencement point for analysis of threshold interpretation. The Court states the following:

“Generally speaking, a serious impairment is one which causes **substantial interference** with the ability of the injured person to perform his or her usual daily activities or to **continue his or her regular employment.**”

“Where...permanent impairment of an important bodily function **frustrates the chosen career path** of an injured person we think the impairment is properly described as being a serious one for that person.”

This terminology describes a continuum of impairment. The words serve as an acknowledgment that there are ranges of impairment from none to a complete loss of one’s ability to do anything. All cases that bear analysis are likely to be in the mid-range – that is, the injury hinders the plaintiff’s ability to work without making it impossible.

It has been suggested that the key concept relative to “substantial interference” is that of “vulnerability”. That is, because of the plaintiff’s impairments, he/she is more vulnerable to income loss – to suffering a “substantial interference” with the ability to continue regular employment or to be hindered in pursuing a “chosen career path”.

There will be little difficulty in establishing seriousness in respect of plaintiffs who are unable to return to any job or who can return to some form of employment in a significantly diminished capacity. The issue becomes more difficult for those plaintiffs who have returned to work by the time of trial – either at their former job or in another job paying equivalent or even higher money. These precepts of vulnerability, competitive disadvantage and marginalization allow one to establish a substantial interference with

one's ability to work. There have been several recent cases where seriousness has been considered in this context.

In *Hall v. Dambrough et al* , the plaintiff was a registered nurse who was employed at Centenary Health Centre at the date of the accident. She graduated as a registered nurse in June, 1989 and immediately started at Centenary. She worked for two years on a medical floor and subsequently moved to the coronary care unit where she worked for one year prior to the accident.

Madam Justice Lax found that the plaintiff suffered soft tissue injuries which mildly impaired the plaintiff from her work as a coronary care unit nurse. The impairment could limit the plaintiff only in the sense that it would be more difficult for her to perform heavy patient lifts and transfers unassisted. There was no impairment in terms of her ability to do any of her other nursing tasks or to work full-time 12 hour shifts.

The Court found that the “regular employment” was as a registered nurse – specifically as a hospital nurse providing patient care. It was not as a coronary care unit nurse. In addition to finding that her regular employment was as a registered nurse in a hospital setting, the Court found that her “chosen” career was as a hospital nurse involving patient care. Important evidence was led that the plaintiff was forced into coronary care unit originally as a result of a closure of other units at the hospital because of hospital cut backs. Thus, it was more difficult to establish that it was a “chosen career” as opposed to happenstance.

Further, the Court found that the mild, permanent impairment did not limit the plaintiff's ability to work as a registered nurse which the Court concluded “is all that she ever hoped or wanted to be.”

In contrast to the *Hall* decision, are *Earl v. Lang* and *Rutherford v. Pannunzio*. In *Earl v. Lang* , the plaintiffs were husband and wife who were injured in a motor vehicle accident in 1990. Gary Earl suffered a comminuted fracture of the right femur. At the time of the accident, he was employed as an agricultural technician with Kemptville Agricultural College. He was able to return to work full-time after the accident (after a six month absence) in a different capacity.

The plaintiff was unable to do the kind of work that he had been doing at the time of the accident and was confined to laboratory and office work that he found less enjoyable. Evidence was led that the employer appointed Mr. Earl to a new position without holding a competition. The Court concluded that although the plaintiff had lost no income to the date of trial, he was fortunate that his employer had effectively tailor made a position for him “to accommodate the additional physical disability caused by the accident”. Further, the Court noted that there was a “certain degree of uncertainty in his employment future”. The Court was satisfied on all of the evidence that he was “at a more competitive disadvantage with his present disabilities than he was prior to the motor vehicle

accident”.

Accepting there was no loss of past income, the Court found there was a real and substantial risk of future income loss although it acknowledged that in his case the risk was minimized by the plaintiff’s employment history, his reputation for hard work and his personal courage. The Court found a fair and reasonable award in respect of loss of future income would be \$50,000.00.

The decision of Madam Justice Leitch in *Rutherford v. Pannunzio* , was decided on motion. In *Rutherford*, the plaintiff was employed as a senior staff claims representative with Allstate Insurance. He sustained soft tissue injuries to his neck and low back which caused continuing pain and discomfort and impaired his ability to stand or sit in one position, work with his arms above the level of his shoulders, do heavy lifting or perform repetitive bending or twisting at the waist.

The plaintiff had missed no time from work as a result of the accident and said that he worked in spite of his pain. Evidence was led that the plaintiff was concerned about his job performance. In fact, there had been two meetings with this employer two years prior to the motion where the employer expressed their concern and expressed the need for improvement. There was no affidavit evidence from the employer and there was no indication that there was any further concern from the employer to the date of the motion.

Further, the Court found that the plaintiff’s salary had not been affected by the accident and that since the accident, his employment income had continued to increase with the plaintiff obtaining the maximum annual merit salary increase each year since the accident as had occurred prior tot the accident.

Madam Justice Leitch found that the impairment was serious because the plaintiff suffered a substantial interference with his ability to perform his usual and regular job functions. Thus, the Court was prepared to find that one’s regular employment may have been substantially interfered with even though one remains employed in the same capacity as pre-accident earning the same income without time loss.

In addition to finding that the impairment was serious because of the job impairment, Madam Justice Leitch found the impairment was serious because the plaintiff suffered a substantial interference with his recreational activities. The plaintiff was highly energetic and athletic. He was a licensed pilot, an avid scuba diver, enjoyed boating and fishing. In addition, he was an accomplished cabinetmaker and played baseball and bowled.

Virtually all of these activities were discontinued except bowling. The Court appeared to equate a substantial interference with his ability to perform recreational activities with an inability to perform his usual daily activities.

Anther case which emphasizes the subjective nature of the threshold interpretation is that

of *Brough v. Templeton et al.* At the time of the accident, Mrs. Brough was employed in a sales and management capacity with a fitness facility. The Court found that the plaintiff had been highly motivated in athletics ever since being a child and for several years preceding the accident her enjoyment of athletics was conducted at a very high level.

In the decision, the Court emphasized the role which job satisfaction plays on a person's growth and development and specifically recognized the importance which the Plaintiff placed on performing her chosen career as an athletic club director which she was no longer able to do. Accordingly, the Court held that the diminution in her capacity to perform the employment of her choice had been very significant for her and constituted a serious impairment.

The concepts of "loss of competitive advantage", "vulnerability" and "marginalization" as they relate to the threshold were explored in the trial judge's decision in *Leszczynski v. Clark*. In that case Madam Justice Corbett held that because the plaintiff was an unskilled worker, the further marginalization was a substantial interference of his employment, notwithstanding that his employment was and continued to be that of an unskilled labourer. The Court further found that because he was a marginal worker, an injury to his back had a greater impact than on someone who was a semi-skilled or even a skilled labourer and that in all likelihood he would be confined to work at minimum wage levels. Accordingly, the Court found that a bad back for this marginal, unskilled worker was a serious impairment. It should be noted that the Court of Appeal dismissed the appeal stating that there was no palpable error and that the findings of serious must be on a case-by-case basis.

There have also been three threshold decisions under Bill 164. The leading decision under Bill 164 is *Marleau v. Falconer*. In *Marleau*, the plaintiff was a 12 year old student who suffered a comminuted fracture of the pelvic area. She was in traction for approximately four months and in a body cast one or two months thereafter. She returned to school within six months and was able to return to playing sports. There was a divergence of medical opinion as to whether the plaintiff suffered increased risk of developing arthritis. The plaintiff had minor residual complaints of achiness when she "overdid it".

Mr. Justice Kerr held that if a plaintiff suffers a serious disfigurement or a serious impairment of an important bodily function, of **no matter what duration**, the claim for damages crosses the threshold. Accordingly, the Court held that as the plaintiff's bodily functions were interfered with for approximately six months the impairment crossed the threshold.

In *Redigonda v. Zogala*, the plaintiff was a 60 year old widow who sustained soft tissue injuries in a car accident. She was off work for approximately 41 months following the accident but subsequently, returned to work gradually part-time and on light duties. The plaintiff suffered chronic pain which was expected to continue indefinitely.

Mr. Justice Killeen followed the decision of Mr. Justice Kerr commenting “that it is well reasoned”. Justice Killeen noted that the threshold had substantially “softened” the earlier threshold by removing the words “permanent” and “continuing”.

It should be noted that as the Bill 59 threshold includes the word “permanent”, the foregoing two decisions would not be applicable to a Bill 59 claim.

The third decision interpreting the threshold under Bill 164 is that of *Robb et al v. Becking*. In *Robb*, the plaintiff suffered soft tissue injuries to his neck and back in a bicycle accident. The neck and back injuries had resulted in headaches and limitation in the plaintiff’s activities. The plaintiff suffered from epilepsy and had been on a disability pension due to his condition for several years pre-accident. He had been effectively unemployed his entire adult life. At the time of the accident, the plaintiff lived with his mother and stepfather, both of whom were in very poor health and who required assistance from the plaintiff in carrying out activities of daily living. Mr. Robb did all of the housekeeping chores for his mother with some help from his stepfather and was responsible for the outside upkeep of the home. Prior to the accident, the plaintiff was physically active engaging in regular cycling, walking, ball hockey and baseball.

Since the accident and because of pain in his neck, back and leg, the plaintiff gave up floor hockey and baseball and significantly reduced his walking. Other tasks for which he was primarily responsible including lawn cutting, grocery shopping and snow shovelling took much longer to accomplish. The plaintiff’s social activities had been significantly curtailed and he felt dependant on other people to assist him in his daily activities including his care giving activities to his mother and stepfather.

Although the plaintiff received no remuneration in caring for his mother and stepfather, the Court found his role as a caregiver to be a “chosen career path” that had been interfered with. There was no express finding by the Court that the plaintiff was unable to fulfill his functions as caregiver; however, the Court did note that the pain affected his ability to do these tasks in such a way that it interfered with his ability to pursue his own interests because of the extra time required to perform his household tasks.

Following the subjective approach, the Court emphasized that the limitations the plaintiff had prior to the accident due to his disability, lack of education and job experience led to his having been impacted to a far greater degree than some other individual may have been. Accordingly, the Court found that the plaintiff crossed the threshold.

It should be noted that there have been no reported rulings under Bill 164 where cases have not met the threshold. Although currently there are no threshold decisions under Bill 59, it will be interesting to see whether or not the inclusion of the word “permanent” will have any affect on the perpetual erosion of the threshold. It would appear that the duration of the injury is relevant to the Bill 59 threshold, and therefore *Marleau* would

not be applicable to that regime.

Although the cases under Bill 164 have arguably eroded the threshold to almost non-existent, there is also a monetary threshold under Bill 164 and Bill 59 which are applicable.

The Monetary Threshold

Bill 164 introduced the concept of a general damage deductible. This deductible was also implemented into Bill 59. According to section 267.5(7), after assessment of the loss, the amount of damage is to be reduced by the amount of a non-pecuniary damage deductible. The amount is \$15,000.00 for the injured party. If there is a person making a derivative claim under the *Family Law Act*, their entitlement is also to be assessed and then reduced by \$7,500.00.

Ironically, it appears that the damage deductible has more serious ramifications for the more serious injuries as opposed to the more trivial ones. That is because while the damage assessments for the less serious injuries seemed to have increased in order to circumvent the implications of the deductible, the assessments have not increased with respect to the more serious injuries.

As an example, a one year whiplash injury assessed pre-OMPP would likely have been assessed in the \$5,000.00 to \$10,000.00 range. Assuming the injury crosses the Bill 164 verbal threshold, that same injury is now likely to be assessed at \$10,000.00 to \$20,000.00 to offset the effect of the verbal threshold.

However, the closed head injuries, severe multiple fractures, and paralysis cases, to name just a few, do not seem to have had the same adjustments made with respect to the assessment of the damages. Thus, it would appear that under Bill 164, we are seeing an eroding verbal threshold, with an increase in assessment of damages to offset the monetary threshold on less serious injuries, with the effect of the monetary threshold only being felt by the more seriously injured claimants.

Projecting forward under Bill 59, the re-introduction of the word “permanent” will likely slow down the trend to weaken the verbal threshold, if only somewhat. The fact remains that Mrs Meyer, in the hallmark Court of Appeal decision of *Meyer v. Bright* did not cross the threshold. Claimants with seemingly far less significant injuries are crossing now, likely because the Court of Appeal has suggested how one presents a case to be both “serious” and “permanent”, such that if Mr. Gilby acting for Mrs. Meyer were to re-argue his case today, there is little doubt that her claim would also cross the threshold.

Thus, the downward trend towards litigation over personal injuries has likely stopped. Counsel are buoyed with the prospect of receiving not just modest general damages for

small soft tissue injuries as was the case in Bill 164, but also with the prospect of some recovery for lost income, and most importantly, future loss of income under Bill 59. It is anticipated that once the public is better informed by the plaintiff's bar of the prospects for recovery in tort again, the trend towards litigation of tort claims which was so prevalent just before the enactment of OMPP, will once again remerge.

PROCEDURAL CHANGES TO BILL 59: PATHWAYS AND PITFALLS

The Treatment Plan

The use of treatment plans has significantly altered the manner in which medical and rehabilitation benefits are to be delivered to insured persons.

Section 2(1) defines a treatment plan as follows:

“Treatment Plan” means, in respect of an insured person who sustains an impairment as a result of an accident, a document prepared by a member of a health profession that includes,

- (a) a description of the impairment,
- (b) a description of any disability that results from the impairment and an estimate of the duration of the disability,
- (c) a description of the goods and services that will be used in the treatment or rehabilitation of the insured person and a description of the benefits that are anticipated from the goods and services,
- (d) a statement identifying the persons who will provide the goods and services,
- (e) an estimate of the duration of the services,
- (f) an estimate of the costs of the goods and services,
- (g) a statement identifying a member of a health profession who will supervise the implementation of the treatment plan,
- (h) a statement by a health practitioner indicating that he or she approves of the treatment plan and is of the opinion that the expenses contemplated by the treatment plan are reasonable and necessary for the insured person's treatment or rehabilitation, and
- (i) the statement required by subsection 38(3).

Section 38 outlines the treatment plan provisions as follows:

1. Before expenses in respect of which a medical or rehabilitation benefit may be payable are incurred, the insured person shall submit an application for the benefit to the insurer.
2. The application must include a treatment plan.
3. The treatment plan shall include a statement by the member of a health profession who prepared the plan,
 - (a) disclosing any conflict of interest that he or she had relating to the treatment plan;
 - (b) indicating that he or she has made reasonable inquiries to determine whether any person who referred the insured person to a person who will provide goods or services contemplated by the treatment plan has a conflict of interest relating to the treatment plan;
 - (c) disclosing any conflict of interest that a person who referred the insured to a person who will provide goods or services contemplated by the treatment plan has relating to the treatment plan.
4. A lawyer or other representative who acts for the insured person in respect of the application or in respect of any civil proceeding arising from the accident shall, at the time the application is submitted, give the insurer and the insured person written notice disclosing any conflict of interest that the lawyer or other representative has relating to the treatment plan.
5. If a conflict of interest is disclosed under subsection (3) or (4), the insurer may, within 14 days after receiving the application, give the insured person notice that the application is refused and that the insured person may submit a new application.
6. Subsection (5) does not apply if there is no other person within 50 kilometres of the insured person's residence who is able to provide the goods or services from which the conflict of interest arises.
7. On receiving the application, the insurer shall promptly determine whether the insurer is required to pay for the goods and services contemplated by the treatment plan.
8. If no notice is given under subsection (5), the insurer shall, within 14 days

- after receiving the application, give the insured person a notice,
- (a) stating that,
 - (i) the insurer will pay for all goods and services contemplated by the treatment plan,
 - (ii) the insurer will pay for such goods and services contemplated by the treatment plan as are specified in the notice, or
 - (iii) the insurer will not pay for any goods and services contemplated by the treatment plan; and
 - (b) disclosing any conflict of interest that the insurer has relating to the treatment plan.
11. If the application not withdrawn under subsection (9), the insurer shall pay for goods and services described in the notice under subclause (8)(a)(i) or (ii) within 30 days after receiving an invoice from them.
12. If the notice under clause (8)(a) indicates that there are goods or services contemplated by the treatment plan that the insurer will not pay for,
- (a) the insurer shall require the insured person to be assessed in respect of those goods and services by a designated assessment centre in accordance with section 43; and
 - (b) the insurer shall include in the notice under subsection (8),
 - (i) a statement of the insurer's reasons for not agreeing to pay for all goods and services contemplated by the treatment plan, and
 - (ii) notice that the insurer requires the insured person to be assessed by a designated assessment centre in accordance with section 43.
13. Despite clause (12)(a), no assessment by a designated assessment centre shall be required if, within seven days after receiving the notice under subclause (12)(b)(ii), the insured person gives the insurer written notice that he or she will not make any claim in respect of the goods or services that the insurer has indicated it will not pay for.
14. Subject to the determination of a dispute relating to the expense in accordance with sections 279 to 283 of the *Insurance Act*,
- (a) if a report from the designated assessment centre states that, in the opinion of the person or persons who conducted the assessment, an expense is reasonable and necessary for the insured person's treatment or

rehabilitation, the insurer shall pay for the expense;

- (b) if a report from the designated assessment centre does not state that, in the opinion of the person or persons who conducted the assessment, an expense is reasonable and necessary for the insured person's treatment or rehabilitation, the insurer is not required to pay for the expense.

15. Despite subsection (12), an insurer shall not require an assessment by a designated assessment centre, and shall not give the notice referred to in subclause (12)(b)(ii), in respect of a claim for the following expenses:

1. Expenses for assistive devices partially paid for by the Ministry of Health, including wheelchairs or other mobility devices, prostheses and orthotic.
2. Expenses for prescription eyewear, hearing aids, or dentures or other dental devices.
3. Expenses for transportation to or from counselling sessions, training sessions, treatment sessions or assessments, including transportation for an aide or attendant.
4. Vocational rehabilitation expenses payable by the insurer until a dispute over either a benefit is payable under the *Workers Compensation Act* is resolved.

16. Subject to subsection (14), if the treatment plan contemplates goods and services provided by a chiropractor or physiotherapist, the insurer shall, despite requiring the insured person to be assessed by a designated assessment centre under subsection (12) in respect of those goods or services, pay for all expenses incurred, after submission of the treatment plan, in respect of those goods and services, up to the lesser of the following amounts:

1. The total expenses incurred on behalf of the insured person in respect of the first 15 treatment sessions with a chiropractor or physiotherapist after the accident.
2. The total expenses incurred on behalf of the insured person in respect of all treatment sessions with a chiropractor or physiotherapist within six weeks after the accident.

17. If an insured person incurs expenses in respect of which a medical or rehabilitation benefit may be payable without complying with subsection (1),(2) or (3), the insured person shall submit to the insurer an application for payment of the expenses that complies with subsections (2) and (3) within 30

- days after incurring the expenses.
18. Despite subsection (1), if the insurer receives an application under subsection (17), the insurer shall, within 30 days after receiving the application,
 - (a) pay the expense; or
 - (b) give the insured person notice of its reasons for not paying the expenses.
 19. If, after giving notice under subclause (8)(a)(i) or (ii), it comes to the attention of the insurer that a person described in subsection (3) or (4) has a conflict of interest relating to the treatment plan, the insurer may give the insured person notice requiring the insured person, within 14 days after receiving the notice, to amend the treatment plan to remove the conflict of interest.
 20. If the insured person does not comply with a notice under subsection (19), the insurer is not required to pay for any further expenses for goods or services from which the conflict or interest arises.
 21. Subsection (20) does not apply if there is no other person within 50 kilometres of the insured person's residence who is able to provide the goods or services from which the conflict of interest arises.
 22. Subsections (1) to (21) do not apply if the insurer agrees to pay for expenses without the submission of an application or treatment plan.
 23. If the insurer agrees to pay for expenses without the submission of an application or treatment plan, the insurer shall give the insured person a notice disclosing any conflict of interest that the insurer has relating to any goods or services to which the insured person is referred by the insurer.
 24. For the purpose of this section,
 - (a) a person has a conflict of interest relating to a treatment plan if,
 - (i) the person or a member of the person's family may receive a financial benefit, directly or indirectly, as a result of the provision, by a member of the person's family or another person, of goods or services contemplated by the treatment plan, and
 - (ii) the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services under which goods or services of that kind are provided; and

- (b) an insurer has a conflict of interest relating to goods or services to which an insured person is referred by the insurer if the insurer may receive a financial benefit, directly or indirectly, as a result of the provision of the goods or services.

25. In clause (24)(a), “member of the person’s family” means, in the case of a person who is not a corporation, any other person connected with the person by blood relationship, marriage or adoption, and

- (a) persons are connected by blood relationship if one is the child or other descendent of the other or one is the brother or sister of the other,
- (b) persons are connected by marriage if one is the spouse of the other or of a person who is connected by blood relationship to the other, and
- (c) persons are connected by adoption if one has been adopted, either legally or in fact, as the child of the other or as the child of a person who is connected by blood relationship (otherwise than as a brother or sister) to the other.

As has been stated before, these provisions change the OMPP and Bill 164 concepts of “pay now, dispute later”. If an insurer is not happy with the treatment plan that the insured has submitted, sections 38 allows the insurer to refuse to pay for the goods and services outlined in the treatment plan and request an assessment from a designated assessment centre.

The treatment plan must be provided before the expense is incurred. Any expenses incurred before treatment plan is provided to the insurer are simply not payable. If the insurer disputes the treatment plan as submitted, it must do so within 14 days by seeking a designated assessment centre assessment. Once the referral has been made to the designated assessment centre, the insurer has no obligation to pay for any treatment until the designated assessment centre report is received. It is for that reason that an exception has been made to allow payment of the lesser of 15 physiotherapy or chiropractic treatments or the first six weeks of physiotherapy or chiropractic treatments in order to bridge the gap between the accident and the receipt of the designated assessment centre report. It must be noted that if the insured does not provide a notice of denial of payment of the benefits, with reasons, within 14 days of receiving the application with the completed treatment plan, or fails to make the referral to the designated assessment centre within 15 days of that Notice of Refusal, it is arguable that the insurer may lose its right to refuse the treatment plan and further lose the right to have the insurer assessed by the designated assessment centre.

The problems seen with respect to the treatment plans has been the timing of them. A lot of the more “questionable” treatment facilities will provide a treatment plan to an insurer

dated before the treatments commenced, but strangely, will not be received by the insurer until much later. Insurers are having to prove that the date stamp on the document is indeed correct, and that the plan was received late. They are being faced with the dilemma of seeking to deny a treatment plan which on its face, has been provided properly.

Another problem being faced is the high cost of challenging a treatment plan. There are no guidelines regarding the length of a proper treatment plan. A lot of treatment providers are keeping the time frame short, so that the high cost of the designated assessment centre retained to assess the reasonableness of the treatment plan will in many instances exceed or at least match the cost of the treatments themselves. Many insurers are finding themselves in the dilemma of paying the DAC \$1,500.00 to reject a \$1,200.00 treatment plan.

However, with the recent introduction of the fees and treatment protocol from the Ontario Insurance Commission, it is hoped that the days of skyrocketing medical and rehabilitation costs and unscrupulous treatment providers is, if not over, then certainly on the drastic decline.

The Conflict Rules

The conflict of interest provisions with respect to the treatment plan are quite intricate and are delineated in various subsections to section 38 of the *Bill 59 Schedule*.

Generally, the health professional who prepared the treatment is required to disclose any conflict of interest that he or she has relating to the treatment plan as well as indicate that reasonable inquiries were made to determine whether any person who referred the insured to the treatment service provider has a conflict of interest relating to the treatment plan and to disclose such conflict if one exists. In addition, the insured's legal representative is to disclose to the insurer any conflict of interest that he or she may have relating to the treatment plan.

If a conflict of interest is disclosed the insurer has within 14 days after receiving the application for benefits to refuse the application in which case the insured can submit a new treatment plan. If no conflict of interest is initially disclosed but an insurer discovers one later on, it may then give notice to the insured advising him or her of the conflict and request that the insured amend the treatment plan to remove the conflict of interest within 14 days after receiving notice from the insurer. If the insured does not comply with the notice in the requisite time period, the insurer can refuse to pay any of the expenses pertaining to the conflict.

A conflict of interest arises if a person or a member of a person's family will receive a financial benefit directly or indirectly as a result of the provision by a member of a

person's family or another person of goods or services contemplated by the treatment plan. Excluded from this is anyone who is an employee of the person or who is under a contract with the person to deliver the types of goods and services addressed by the plan.

The "member of a person's family" is defined as not to include any individual who is a corporation but otherwise generally covers various levels of blood relationships, relationships by marriage and relationships through adoption (see section 38(25)).

Although the conflict rules were designed to eradicate "kickbacks" passing from the service provider to the creator of the treatment plan or to the insured's legal representative, the obvious conflict of self-referral is excluded. If, for example, a physiotherapist prepares the treatment plan, there is nothing in the conflict rules that would preclude him or her from referring the insured for physiotherapy treatment at his or her own treatment facility. This exclusion is contrary to common sense and has been perceived to be an oversight on the part of the drafters. However, if this provision is not changed as at the time of the bi-annual review of the system later this year, we will know that it was not an oversight, but instead was the product of some very effective lobbying by the medical and rehabilitation community.

It should also be noted that there is also a provision dealing with an insurer's conflict of interest which operates in a manner to preclude the insurer from receiving financial benefits, directly or indirectly, as a result of the provisions of goods and services. This provision has really not come into play to date. However, to the extent that insurers continue to align themselves with preferred vendors and purchase equity in facilities, as some insurers have, this will become a problem. Quere also the very bizarre example of an insurer which is aligned to a financial institution, which financial institution lends money to the treatment facility with the expectation of profit from that lending.

Suspicious Claims

One of the most troublesome aspects regarding the provisions of Bill 68 and Bill 164 has been in respect of the limited rights insurers have had in investigating and challenging suspicious claims. Insurers have been hard pressed to obtain documentation to support an Applicant's claim where the Applicant and their counsel have chosen to be uncooperative. It has not been uncommon for accident benefit claims to be advanced with the sole information provided to the insurer in support of a claim being the Application for Accident Benefits. When the insurer has sought follow-up information apparent from that which was contained in the Application package, the insurer has often been rebuffed on the basis that compliance had been made with the provisions and that no further information was legally required to be provided.

It is with that background in mind, that it can be stated categorically that the area of Bill 59 dealing with suspicious claims has been greatly improved over past regimes. This area

has been dealt with in the *Statutory Accident Benefits Schedule* and in the amendments to the *Insurance Act* (the “*Act*”). First, the major change in the *Schedule* is section 33, which permits the insurer to obtain pertinent information about the insured. Section 33 states that:

- (1) A person applying for a benefit under this Regulation shall, within 14 days after receiving a request from the insurer, provide the insurer with the following:
 1. Any information reasonably required to assist the insurer in determining the person’s entitlement to a benefit.
 2. A statutory declaration as to the circumstances that gave rise to the application for a benefit.
 3. The number, street and municipality where the person ordinarily resides.
 4. Proof of the person’s identity.
- (2) The benefit is not payable for any period before the person complies with subsection (1).

Subsection (1) of section 33 gives the insurer the right to require more information about the potential legitimacy or illegitimacy of a claim. Subsection (2) of section 33 gives the provision the real “meat and bones”, by allowing the insurer to withhold payments of benefits until the insured complies with an insurer’s request for information.

It must be said that the pendulum has shifted to the insurer in regards to the rights to investigate suspicious claims. If the insurer does not believe that it has secured the “information reasonably required” to determine that person’s entitlement, it need not pay the benefit.

Accordingly, one can anticipate disputes about what information is “reasonably required” by the insurer. The insured does have the right to challenge the decision by way of mediation and then subsequently by way of litigation or arbitration, but until that dispute is resolved, no benefits will be payable unless the insurer changes its position. If the insurer is found to have unreasonably withheld benefits, then the special award or punitive damages claims would apply and of course interest at 2% a month would likely be found payable in such situations.

To date, surprisingly few disputes over the interpretation of section 33 have developed. None have yet to proceed to arbitration. Many have been pursued at mediation, but have resolved at that stage. The largest misconception appears to deal with the insurer’s right to a statement. In one of the drafts of the *Bill 59 Schedule*, section 33 included the right to

a statement under oath. This right was removed in the final version, yet was done with little fanfare and after many insurers had provided training to its adjusters about Bill 59. Accordingly, the right to a statement continues to cause friction in many cases.

However, just as some insurers seem to be seeking more than they are entitled to, from the writers' experience, many insurers are seeking far less than they are entitled to under section 33 before starting to make accident benefit payments. Where the Courts and the Ontario Insurance Commission have been thoroughly disinclined from allowing insurers to recover overpayments to insured persons on the basis of the insurers' reliance on incorrect information, insurers continue to make accident benefit payments which may be based on incorrect or incomplete information. This could be reduced or eliminated with further reliance on section 33.

The second major change comes by way of the addition of subsection 273.1(1) of the *Insurance Act* which states that:

Every insurer shall provide the Ministry of Community and Social Services, a municipality, a board established under the *District Welfare Administration Boards Act* or a band approved under section 15 of the *General Welfare Assistance Act* with such information as may be prescribed by the regulations, including personal information, subject to such conditions as may be prescribed by the regulations.

This section is mandatory, and instructs insurers to pool their information about insureds with other agencies. There is, however, no reciprocal provision in which the agencies must share the information they have about insureds with the insurers. There will certainly be disputes over the insurer's obtaining the reciprocal information from these agencies without appropriate authorization for the release of this information. The privacy aspect of the agency files has not been diminished by the changes in this legislation and for that reason, does not appear to a "two way street".

However, while insurers may not be able to obtain information from government agencies pursuant to the amendments to the *Insurance Act* 273.1(1) of the *Act*, the amendments to the *Compulsory Automobile Insurance Act* by the addition of subsection 15(1) (c.2) makes a significant difference. That provision has the added obligations that :

An insurer, a class of insurers or the Association to provide the Minister of Transportation with such information as may be prescribed by the regulations, including personal information, subject to such conditions as may be prescribed by the regulations.

While the regulation is yet to be promulgated, it is anticipated that it will codify the use of the Insurance Crime Prevention Bureau data bank of claims to be used by insurers and by the Ministry in appropriate circumstances. The use of the Insurance Crime Prevention

Bureau data bank is nothing new. However, there has always been concern that insurers did not have the right to exchange this information with each other in a first party environment. It is anticipated that the addition of this regulation will end speculation that insurers might run into difficulty by referring to the ICPB data base on accident benefit claims.

Depending on the wording of the regulation, insurers may be able to make use of this information to the extent that it can make additional inquiries pursuant to section 33 of the *Schedule* to learn of “information reasonably required to assist the insurer in determining the person’s entitlement to benefits.” As an example, if the ICPB data bank shows that there is another loss six months earlier that had not been disclosed to the insurer, it might then seem reasonable to make inquiries regarding the entitlement from the earlier loss to determine if there are collateral benefits available for which deductions can be made. As this information would determine the person’s entitlement to a benefit, if the information is not forthcoming, then subsection 33(2) of the *Schedule* seemingly provides the insurer with the right to withhold benefits.

This acts as another supplement to a system which is attempting to obtain a comprehensive list of insureds, their personal information, and other information which is relevant to avoid “double dipping” and other tactics.

It should be noted that the provisions of section 48 of the *Schedule* provide insurers with the right to terminate benefits if the insured person has willfully misrepresented material facts with respect to an application for a benefit. One might question how much of a misrepresentation will be necessary to be “material”. More importantly, it will be necessary to determine what benefits can be terminated in the event of a material misrepresentation. One approach would be to apply the case law flowing from the material misrepresentation statutory conditions in fire policies. Whatever approach is ultimately followed, this deterrent to fraudulent claims will be seen as a welcome addition to the no fault delivery system.

Once again, there appear to be no developments by way of testing section 48, in either the Courts or at the OIC as of this date.

CAT DACS: WHAT ARE THEY?

The General Framework

Bill 59 created a definition of “catastrophic impairment” to ensure that people who sustained severe impairments in automobile accident, would have access to a higher level of benefits, to cover the costs of reasonable and necessary case management, attendant service and medical and rehabilitation goods and services. The DAC catastrophic impairment assessment is intended to identify those individuals who apply for

designation as catastrophic and meet the criteria of the definition.

The determination of catastrophic impairment does not equate to any monetary award but rather creates an access to a higher level of benefits. Regardless of the catastrophic impairment determination, subsequent applications for benefits is still subject to review by other DACs (eg. Attendant service or Med/Rehab DACs), should the insurer request the assessment regarding the reasonableness or necessity of expenses.

Apart from the obvious enhanced accident benefits, a determination of “catastrophic impairment” also creates an enhancement of the right to sue in tort. Although under subsection 267.5(3) of the *Insurance Act*, the owner of an automobile, the occupants of an automobile and any person present at the incident are not liable for damages for expenses that have been incurred or will be incurred for health care resulting from bodily injury arising directly or indirectly from use or operation of the automobile, pursuant to subsection 267.5(4), the aforementioned subsection does not apply if the injured person has sustained a catastrophic impairment as defined in section 5(1) of regulation 461/96.

The purpose of the assessment is to determine if the claimant meets the definition of catastrophic impairment as set out in section 2 of the *Schedule*, and also for the same determination in tort under section 5(1) of Regulation 461/96 in respect of section 267.5(4) of the *Insurance Act*.

The assessment may be triggered in one of two ways:

A claimant applies for a determination of whether an impairment is catastrophic and the insurer disagrees, or,

A claimant applies for a determination of whether an impairment is catastrophic and the insurer requests that a CAT DAC assess a claimant before the insurer accepts or denies the request.

The application for catastrophic impairment determination will state the reasons, held by the practitioner completing the application, regarding why their patient meets the definition. According to the CAT DAC interim manual, this should not however ‘limit’ the CAT DAC assessment to exploration of only the impairment(s) identified in the application. This principle recognizes that there may be many practitioners, especially in the early days of Bill 59’s life, who, while authorized to complete the application, do so with an incomplete understanding of the legislation – claimants should not be disadvantaged by this. It is therefore, the CAT DAC’s responsibility to ensure that a comprehensive assessment of each claimant’s impairment(s) be conducted to determine if they have impairment(s) that would qualify as catastrophic.

This principle should not however, open the door to inefficient assessments that ‘over-assess’ the claimant. Accordingly, the intake process and assessment protocols have been

designed to focus the assessment appropriately and, where possible, to ‘stage’ assessments so that only necessary investigations are undertaken. Additionally, procedures that are time-consuming and more resource-intensive are staged last, with decision check-points that ensure only those claimants who require such assessments progress to this level.

The assessment process commences with an in-depth review of documentation supplied by the insurance company and the claimant. This information is imperative to decision-making regarding selection of the assessment team and formation of an understanding of the claimant’s history. In some cases, there will be sufficient information to allow decisions to be made without the need for direct assessment of the claimant. Under the assessment protocols, there are mechanisms to make use of previous assessment material where appropriate and for direct assessment where necessary.

An individual assessment may be conducted by a single practitioner or a multi-disciplinary group depending on what is appropriate in the circumstances.

The CAT DAC has access to a pool of appropriately experienced and skilled clinical experts including: physicians, psychologists, occupational therapists, physiotherapists, speech-language pathologist/audiologists, chiropractors, and other health professionals.

Definition of “Catastrophic”

Section 2 of the *Schedule* defines catastrophic impairment as:

- (a) paraplegia or quadriplegia
- (b) amputation or other impairment causing the total and permanent loss of use of both arms
- (c) amputation or other impairment causing the total and permanent loss of use of both an arm and a leg
- (d) total loss of vision in both eyes
- (e) brain impairment that, in respect of an accident, results in;
 - (i) a score of 9 or less on the Glasgow Coma Scale as published in Jennett, B. and Teasdale, G., *Management 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
 - (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

- (f) subject to subsection (2) and (3), any 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 percent or more impairment of the whole person, or
- (g) subject to subsections (2) and (3), any 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.

Clause (f) and (g) of the definition of "catastrophic impairment" in subsection (1) do not apply in respect of an insured person who sustains an impairment as a result of an accident where

- (a) the insured person's health practitioner states in writing that the insured person's condition has stabilized and is not likely to improve with treatment; or
- (b) three years have elapsed since the accident.

For the purpose of clauses (f) and (g) of the definition of "catastrophic impairment" in subsection (1), 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 shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

Assessment Protocol Guidelines

These guidelines have been developed to facilitate the assessment of claimants with brain injuries resulting from motor vehicle accident, with regard to the determination of an impairment designation as catastrophic. The guidelines were developed to conform with the definition of catastrophic impairment set out in the *Schedule*. In the case of brain injury, this definition specifically mandates the use of the American Medical Association *Guides to the Evaluation of Permanent Impairment*, 4th Edition (AMA Guides); or, the use of 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*); or, the Glasgow Outcome Scale (as published in Jennett,

B. And Bond, M., Assessment of Outcome After Severe Brain Damage, *Lancet* i:480, 1975). In addition, the “Principles for Catastrophic Impairment Assessment”, outlined in the introduction of this manual were incorporated in the creation of these protocol guidelines. Accordingly, the assessment protocol addresses:

- **Causation**, the *Schedule* direct that impairments which qualify the claimant for a designation of ‘catastrophic’, must **result directly from the accident**.
- **Stability**, the Glasgow Outcome Scale will not be employed before 6 months have lapsed since the accident, or, in the case of the AMA Guides, the claimant’s condition (if less than 3 years from the date of the accident) must be ‘stabilized and not likely to improve with treatment’;
- **Severity**, the first stage of the assessment will examine the severity of the claimant’s impairment and from this outcome determine which of the Glasgow Outcome Scale (GOS) Protocol or the AMA Chapter 4 protocol is indicated; and,
- The assessment is **Efficient but also Comprehensive**, in keeping with the foundation principles. This is achieved through its ‘staged’ implementation, i.e.: only those claimants who satisfy the earlier (Stage 1) assessment criteria regarding causation and stability will progress to the later and more resource-intensive stage(s) of assessment.

Glasgow Outcome Scale

The Glasgow Outcome Scale (GOS) classifies individuals with brain injuries into one of 5 scores. According to Bill 59, a designation of catastrophic impairment equates to a GOS score of (2) vegetative, or (3) severe disability. To assist in determining if the claimant meets the criteria for either of these classifications, the individual will be assessed to determine his/her level of functioning in Activities of Daily Living (self-care, productivity and leisure).

In planning the assessment protocol, the original article referenced in the *Schedule* was consulted. The GOS authors (Jennett, Snoek, Bond and Brooks, 1981) define severe disability related to Activities of Daily Living (ADL) dysfunction as:

Severe Disability: This indicates that a patient is conscious but needs the assistance of another person for some activities of daily living every day. This may range from continuous total dependency (for feeding and washing) to the need for assistance with only one activity – such as dressing, getting out of bed or moving about the house or going outside to shop. More often dependency is due to a combination of physical and mental disability...”(they) cope at home with support of attentive relatives, but could not be left overnight because they would be unable to plan their meals or deal with callers, or

any domestic crisis which might arise.” (p. 286)

In addition, an examination of the Glasgow Outcome Scale (GOS) Extended Version was used to more explicitly describe the functional activities that separate the brain-injured person with ‘severe disability’ from the brain-injured person with ‘moderate disability’. This revealed that to be classed above the level of ‘3’ (severe disability) the claimant should be capable of:

Travelling and shopping locally without assistance and should also not require the assistance of another person at home for ADL and be capable of being left alone at home for up to 8 hours during the day.

American Medical Association’s Guidelines

In 1958, the American Medical Association formed a committee on the rating of physical impairment. Over a period of thirteen years, that committee, and some smaller subcommittees, prepared various papers on the evaluation of impairments for various body systems.

The American Medical Association collected the thirteen separate articles and compiled the first edition of the “Guides to the Evaluation of Permanent impairment”. The fourth edition which is three hundred and thirty-nine pages and set out in 15 chapters was completed in June of 1993. In sum, it does not make easy reading, even for the initiated.

The *Schedule* specifically mandates the use of the American Medical Association’s Guides to the Evaluation of Permanent Impairment, 4th edition. This classification and rating system has several applications under the *Schedule*. Under section 2 of the *Schedule*, subject to subsections (2) and (3), a person has a catastrophic impairment if the impairment or combinations of impairment results in 55 per cent or more impairment of the whole person as per the *American Medical Association’s Guides to the Evaluation of Permanent Impairment, 4th edition*. In addition, subject to subsections (2) and (3) a person is catastrophically impaired if he or she has a class 4 impairment (marked impairment) or a class 5 impairment (extreme impairment) due to a mental or behavioural disorder.

Depending on the claimant’s impairments, some will not require extensive assessment due to the obviousness of the impairment (eg amputations, spinal cord lesions and visual loss). Others will be assessed using the Mental and Behavioural Disorder assessment or the Glasgow Outcome Scale protocol. However, it is anticipated that a significant number of claimants will be assessed to determine if their impairment(s) equal or exceed 55% whole person impairment. For these assessments, the Guides must be consulted and relied on.

It must be noted that the use of the AMA Guides has been viewed by experienced medical and legal consultants from the United States familiar with its use over the years as being somewhat surprising, since the AMA Guides are very complex to interpret, were not designed to be used in dealing with assessment of disability for the purpose of establishing compensation, and the 4th edition being used, was already superseded before the enactment of Bill 59. The 4th edition being used in Ontario makes a clean delineation between physical and non physical impairments. Thus, if someone has an amputated arm upon which he has superimposed depression and anxiety, then the amputated arm must get to 55% of the whole body impairment (which it does not) or must have a class 4 or 5 mental or behavioural disorder on its own, in order to be declared as catastrophic. Dealing with concepts such as chronic pain syndrome, fibromyalgia and post traumatic stress disorder are similarly complex.

Impact to Date

As there have been relatively few CAT DAC assessments to date, at this point it is too early to determine how they will be perceived by the accident victim, the insurance industry, and the legal and medical community in general. I have not doubt that these assessments will engender scrutiny and debate in the imminent future.

NOTICE REQUIREMENTS – HOW “REQUIRED” ARE THEY?

Section 258.3(1) of the *Insurance Act* requires the plaintiff to carry out a number of steps before commencing an action in the Courts. The plaintiff must:

1. apply for statutory accident benefits;
2. serve written notice of the intention to commence an action on the defendant within 120 days after the incident, unless the time is extended by the Court;
3. provide the defendant with the information prescribed by the regulations within the time periods prescribed by the regulations.
4. have undergone medical examinations, if requested by the defendant within 90 days after receiving notice of the action and at the defendant's expense;
5. provide the defendant, if requested by the defendant, with a statutory declaration describing the circumstances surrounding the incident and including information regarding the nature of the claim; and
6. provide the defendant, if requested by the defendant, with evidence of the

plaintiff's identity.

In respect of paragraph number 3 above, generally the Regulation requires the plaintiff to provide the defendant with the following information within 30 days after serving the notice of action: the name of the plaintiff's insurer; evidence of the plaintiff's income from all sources for the 52 weeks immediately preceding the accident, if a claim is being made in respect of income loss; and a copy of the autopsy report, if the claim arising is out of a person's death.

In addition the plaintiff must also provide the defendant with the following: a copy of every application made by the plaintiff for statutory accident benefits that the plaintiff submitted to his/her insurer as a result of the incident and all other material submitted to his/her insurer in respect of the application for statutory accident benefits; a copy of every medical report prepared for the plaintiff in respect of injuries arising from the incident and prepared during the period commencing at the time of the incident and ending on the day the written notice of the actions served or 120 days after the incident whichever is later and; a copy of any clinical notes and records prepared by all health care professionals (meaning member of a College defined in the *Regulated Health Professions Act, 1991*) who cared for the plaintiff in respect of injuries arising from the incident; during the period commencing at the time of the incident and ending on the day the written notice of the action is served or 120 days after the incident whichever is later.

Sections 258.4 and 258.5 of the *Insurance Act* set out the responsibilities of the insurer. These responsibilities include: promptly informing the plaintiff whether there was a motor vehicle policy issued by the insurer and whether the insurer will respond under the policy to the claim and; upon receiving the initial notice of the action and throughout the defence of the claim, the insurer shall attempt to settle the claim as expeditiously as possible and; if the insurer admits liability in respect all or part of a claim for income loss, the insurer shall make advance payments pending the determination of the amount owing.

Although the *Act* prescribes detailed notice and disclosure provisions, the ramifications of non-compliance set out in section 258.3 (9) are trivial. Under that section, a person may commence an action without complying with the notice and disclosure requirements, but the court shall consider the non-compliance in awarding costs.

Therefore, not only does the *Act* not preclude an action from being commenced in the face of non-compliance with the provisions, the courts do not even have to impose cost sanctions- it only has to **consider** the non-compliance in awarding costs. Once the Court has a discretion not to impose a penalty, the likelihood of it doing so is remote. Moreover, a court will only have the opportunity to impose cost sanction for non-compliance if the action is actually litigated. However, in excess of 90% of the cases are resolved prior to trial.

The general reluctance of the courts to impose a penalty on a plaintiff in a tort case, coupled with the likelihood of the matter settling before trial renders the notice and disclosure provisions toothless. This is conducive to either the total or partial disregard of the provisions by counsel, which to date, has been the experience of many insurers. Insurers can commence an Application in court (which is an initiating process), to compel a plaintiff to comply with its obligations under the *Act*. The costs of such a pursuit, usually requiring the retention of counsel at an early date, has generally not been perceived by insurers as worthwhile in order to compel the productions required. Taking such a step will also likely make plaintiff's counsel unreceptive to waiver of any non compliance by the insurer, such as in pursuing advance payments by way of motion, seeking admissions of liability by way of motion, and most significantly, by refusing to grant waivers of defence once a statement of claim is issued.

THE INTERFACE BETWEEN ACCIDENT BENEFITS AND TORT

Under section 267(1)(a) of the *Insurance Act*, the damages awarded to a person in a tort action with respect to an automobile accident shall be reduced by all payments that the person has or that was or is available for statutory accident benefits and by the present value of any statutory accident benefits to which the person is entitled.

Although Bill 59 decisively addresses the interface between accident benefits and tort damages, the prior regimes were rife with controversy and confusion in that regard. Although the cases of *Whittle v. Ontario*, *Orchover v. Wright* and *Chrappa v. Ohm* are all instructive with respect to the OMPP interface, (there is no interface in respect of Bill 164,) the latter case provided the foundation for our current regime with respect to future payments.

In *Chrappa* at the time of trial, the plaintiff was receiving disability benefits under a group policy with Great West Life. However, it was not known whether Great West Life would continue payments into the future as the plaintiff had been subjected to a defence medical examination by Great West shortly before trial. The present value of future disability benefits was ascertained at trial to be approximately \$150, 000. At issue was whether or not the defendant was entitled to deduct the potential future disability benefits from the jury award. In that case, Madam Justice Lax articulated the issue as to whether or not it could be said that the plaintiff was "entitled to those benefits as per section 267(1)(c) of the *Act*."

In that case, Madam Justice Lax. held that it could not be said that a person was "entitled" to the present value of payments to be made under an income continuation plan unless the payments *would be received*. Accordingly, she further stated that the deduction of the present value of section 267(1)(c) payments was only warranted if the facts established that it was beyond dispute that the plaintiff qualified in every respect. As the facts did not unequivocally establish this, the defendant was not allowed the deduction.

Recognizing that the foregoing result could be inequitable for the tortfeasor, Madam Justice Lax. then required that the plaintiff hold in trust for the defendant any benefits received from Great West Life. The plaintiff was also required to assign her rights against Great West Life to the tortfeasor and to cooperate in the prosecution of any such action. To protect the plaintiff, the tortfeasor was ordered to re-assign the right to claim against Great West Life in the event that the full amount of the judgement against the defendant was paid by Great West Life.

Chappra set the stage for the Bill 59 interface provisions contained in section 267.8 of the *Insurance Act*. That section contains 22 subsections with respect to collateral benefits and interface issues. Although a detailed discussion of section 267.8 is beyond the scope of this paper, generally that section deals with both the treatment of benefits up to trial as well as the treatment of future benefits.

With respect to the treatment of benefits up to trial, Bill 59 generally codifies the prior law by requiring benefits received before trial to be deducted from damages. However, as there are many exceptions to this general precept, section 267.8 of the *Act* must be consulted for a thorough analysis in that regard.

Subsections (9) through (12) pertain to the treatment of future benefits. Under subsection (9), a plaintiff who receives damages for income loss, loss of earning capacity, health care expenses, or other pecuniary losses are required to hold in trust all of the specified collateral benefits received after trial. Subsection (10) requires the plaintiff to pay these monies to the defendants who paid damages. Any disputes that arise in that regard can be resolved through arbitration at the instance of any person claiming a payment. Under subsection (12), on motion, the court may order that an assignment be made by the plaintiff, and if such an order is made, subsection (9) no longer applies.

The implications of these interface provisions is that if a plaintiff in a tort action is claiming future loss of income or future medical/rehabilitation expenses, or future attendant care expenses, the plaintiff is precluded from settling his or her future accident benefits claim since the tort carrier is entitled to a full credit for such future benefits. Accordingly, this impedes the closing of accident benefit files until the tort claim is resolved. It ill behoves plaintiffs in these circumstances from arbitrating their accident benefit issues at the OIC and deal with their tort issues in Court. Accordingly, there will be more actions where the tort and accident benefits issues will be dealt with in the same forum.

As far as settlement goes, in order to efficiently resolve the accident benefits side of the file, the parties are enticed to enter into private mediations in attempts to settle both the accident benefit side and the tort side of the file. In addition, there will also likely be more requests for the tort carrier to approve accident benefit settlements. However, there

is no practical advantage for the tort carrier to authorize an accident benefits settlement unless the plaintiff agrees to limit the tort claim to a commensurate amount.

CONCLUSION

Although a preliminary discussion pertaining to the ramifications and perceptions of Bill 59 is possible, due to the relatively few cases that have arisen, it is still premature to engage in a decisive analysis. However, even at this point, there can be no denying that many of the foregoing substantive and procedural changes dealing with accident benefits favour insurers, with the perception that the previous accident benefit schemes were one sided towards the insured persons. However, this will likely be offset by the likely proliferation of Bill 59 tort cases, which will necessitate the protection of future accident benefits in favour of the tortfeasor, and therefore cause a number of accident benefit files to remain open until tort cases resolve.

As such, it is predicted that the litigious days of pre OMPP may soon be back. It is hoped that if this prediction is correct, that all stakeholders in the insurance system will act swiftly to ensure that whatever inequities emerge are dealt with in an even handed manner so as to obviate the need for yet another complete overhaul of the delivery of automobile insurance in Ontario.