The Changing Accident Benefits Regime: Ontario Regulation 251/15

By William Sproull

Bill 15, which came into force upon filing on August 26, 2015 (s. 22), will usher in significant changes to the *Statutory Accident Benefits Schedule – Effective September 1, 2010* (O. Reg. 34/10), and will once again alter the relationship between automobile insurers, their customers, and other stakeholders in the Ontario insurance industry. The significant changes, which come into effect as of June 1, 2016, are set out below:

s. 2(1.1)	**ACCIDENTS BEFORE JUNE 1, 2016**: law remains unchanged regarding: • CAT definition (ss. 3(2) – (6)); CAT claim procedure (ss. 45(2) and (4)); • Medical (ss. 15(1)), and Rehabilitation (ss.16 (3)); • Procedure for claiming M/R (s. 38), and Procedure for denying M/R claims (ss. 39(2)); • Deemed applicability of MIG (ss. 40(8)); • Pay pending dispute of ACB pursuant to Form 1 (ss. 42(11) and (15)).
s. 2(1.2) - **TRANSITIONAL PROVISION**	**NEW OR RENEWAL POLICIES**: Bill 15 changes come into effect **AFTER JUNE 1, 2016** with respect to: • NEB benefits: 2 year limit, 4 week deductible (s. 12) • Case manager (ss. 17(1)) • Change to M/R policy limits (ss. 18(3) – (5)) • Change to ACB policy limits (ss. 19(3)) • M/R temporal limits reduced from 10 to 5 years (s. 20) • Changes to Optional benefits (ss. 28(1), (5) and (6), and 30(1) and (4) – (8)) • Post-104 week ACBs (ss. 42(12) and (16)) • Changes to Benefit Statements (ss. 50(3)) • Suspension due to failure to treat (ss. 57(4))
s. 3(1)	Definition of "neuropsychologist" restricted to specialists who have been registered to practice in Canada for a minimum of 5 years.
s. 3.1(1) **CAT IMPAIRMENT**	**NEW DEFINITION** that applies for accidents **ON OR AFTER** June 1, 2016: • ss. 1: Former paraplegia/quadriplegia definition changed to Paraplegia or Tetraplegia meeting the following criteria (i.e., outcome-based):

CRITERIA	

	• 1i - insured's neurological recovery is such that their permanent grade on ASIA Impairment Scale is determinable (as defined in *International Standards for Neurological Classification of Spinal Cord Injury*, Journal of Spinal Medicine, Vol. 26, Supp. 1, Spring 2003); AND
	• 1ii - insured's permanent grade on ASIA is, or will be:
	  • A: A, B or C, OR
	  • B: D, and
	    • 1. Insured's score is 0 – 5 on the Spinal Independence Measure, Version III, item 12 (Mobility Indoors) as defined in *A multicentre international study on the Spinal Cord Independent Measure, version III: Rasch psychometric validation*, Spinal Cord (2007), 45, 275-291, and applied up to 10 metres (even surface),
	    • 2. Insured requires urological diversion (surgical), implanted device, or intermittent/constant catheterization to manage a residual neuro-urological impairment, or
	    • 3. Insured impaired voluntary control of anorectal function that requires a bowel routine, surgical diversion, or an implanted device.
	• ss. 2. Former amputation criteria (b) is now expanded and given more clarity: Severe ambulatory mobility, arm use and amputation impairment that meet:
	  • 2i –leg amputation, at trans-tibial or higher level.
	  • 2ii – arm amputation or other impairment causing total permanent loss of arm usage. OR
	  • 2iii – severe permanent alteration of prior structure and function involving one or both legs such that insured's score is 0 – 5 on Spinal Independence Measure, Version III, item 12 (Mobility Indoors) as defined in *A multicentre international study on the Spinal Cord Independent Measure, version III: Rasch psychometric validation*, Spinal Cord (2007), 45, 275-291, and applied up to 10 meters (even surface).
	• ss. 3. Former criteria (c) for total bilateral vision loss now expanded and given more clarity:
	  • i. – even with corrective lenses or medication usage, bilateral acuity is 20/200(6/60) or less as measure by the Snellen Chart or equivalent, OR, the greatest diameter of bilateral field vision is 20 degrees or less, AND
	  • ii. – loss of vision is not attributable to non-organic causes.
	• ss. 4. Former Glasgow Outcome Score criteria (e) have been expanded for insureds who are 18 or older at time of MVA, but Glasgow Coma Scale (GCS) criteria have been removed, such that traumatic brain injury must meet:

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	• i. – positive demonstrable findings on MRI or CAT scan (or other medically recognized brain diagnostic technology indicating intracranial pathology) resulting from MVA including (but not limited to), intracranial contusions or hemorrhages, diffuse axonal injury, cerebral edema, midline shift or pnuemocephaly, AND • ii. - when assessed under Structured Interviews for the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale: Guidelines for Their Use, Journal of Neurotrauma, Volume 15, Number 8, 1998, the injury results in a rating: • A. Vegetative State (VS or VS*) one month or more after the MVA, • B. Severe Disability, Upper (SD/SD*), or Lower (SD/SD*), six months or more after the MVA, or • C. Moderate Disability Lower (MD/MD*) one year or more after the MVA. • ss. 5. **<u>NEW DEFINITION</u>** for children with brain injury under 18 (formerly children under 16), with an obligation to meet one of five criteria: • i. – insured is accepted as in-patient to public hospital (as named in Guideline) with positive findings on MRI or CAT scan (or other medically recognized brain diagnostic technology indicating intracranial pathology) resulting from MVA including (but not limited to)), intracranial contusions or hemorrhages, diffuse axonal injury, cerebral edema, midline shift or pnuemocephaly, • ii. – insured accepted as in-patient to neurological rehabilitation program in a paediatric rehabilitation facility that is a member of Ontario Association of Children's Rehabilitation Services, • iii. – insured's level of neurological function does not exceed Category 2 (Vegetative) on King's Outcome Scale for Childhood Head Injury (as defined in *A practical outcome scale for paediatric head injury*, Archives of Disease in Childhood, 2001: 84: 120-124) one or more months after MVA, • iv. – insured's level of neurological function does not exceed Category 3 (Severe disability) on King's Outcome Scale (as defined in *A practical outcome scale for paediatric head injury*, Archives of Disease in Childhood, 2001: 84: 120-124) six or more months after MVA, OR • v. – insured's function level remains seriously impaired such that they are *not age-appropriately independent*, and require in-person supervision or assistance for physical, cognitive or behavioural impairments for the majority of the person's waking day after nine months or more following MVA. • ss. 6. Former criteria (f) remains as before (subject to subsections (2) and (5)): physical impairment(s) that is/are 55% (or more) WPI based on AMA Guides, 4th Edition. • ss. 7. New addition of numerical scoring of psychological impairment based on *AMA Guides 6th Edition*, which can be added to physical impairment scoring based on the AMA Guides 4th Edition (subject to subsections (2) and (5)):

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Excluding traumatic brain injury, a mental or behavioural impairment that is determined in accordance with Section 14.6 (Chapter 14) of AMA Guides 6th Edition that when the impairment score is combined with a physical impairment described in paragraph 6 (above) in accordance with AMA Guides 4th Edition results in 55% or more Whole Person Impairment (“WPI”).

ss. 8. Legislative action to overrule Pastore, such that an insured requires 3 out of 4 marked impairments or 1 severe impairment out of 4 to qualify (subject to subsections (3) and (5)):

(1) – insured scores marked impairment on three or more areas of function, or severe on one area of function, as defined in AMA Guides 4th Edition.
(2) – paragraphs 6 and 7 (above) do not apply to an insured who sustains an impairment as a result of an MVA unless:

(a) two years have elapsed since MVA; or
(b) physician-conducted assessment three or months after the MVA determines:

(i) – insured has one or more physical impairments determined in accordance with paragraph 6, or a combination of mental or behavioural and a physical impairment determined in accordance with paragraph 7 that results in 55% or more WPI, and
(ii) – insured’s condition unlikely to improve to less than 55% WPI.

(3) – paragraph 8 (above) does not apply to an insured who sustains an impairment as a result of an MVA unless:

(a) two years have elapsed since MVA; or
(b) physician states in writing that impairment is unlikely to improve to less than a class 4 (marked) impairment in three or more areas of function that preclude useful functioning due to a mental or behavioural disorder.

(4) and (5): <u>NEW</u> CAT deeming provision for insureds under 18 at time of MVA:

insured can be deemed CAT impairment by analogy under paragraphs 6, 7 or 8 where the insured’s impairment can reasonably be believed to be a CAT impairment under one or more of those paragraphs, after taking into consideration the developmental implications of the impairment.

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<u>NON-EARNER BENEFIT</u></td>
<td>For accidents on or after June 1, 2016, an insurer is not required to pay NEB to an insured who is under 18 at the time of the MVA, for the first 4 weeks after the onset of complete inability to carry on a normal life, for more than 104 weeks after the MVA, or to an insured who is eligible to receive and has elected under section 35 to receive either an IRB or Caregiver benefit (this is a Legislative response to Galdamez).</td>
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ss. 15(1)(h) **MEDICAL BENEFITS**	For accidents on or after June 1, 2016, but subject to section 18, the insurer is now required to pay for: "(h) other goods and services of a medical nature that the insurer agrees are essential for the treatment of the insured person, and for which a benefit is not otherwise provided in this Regulation."
ss. 16(3)(l) **REHABILITATION BENEFITS**	For accidents on or after June 1, 2016, but subject to section 18, the insurer is now required to pay for: "(l) other goods and services that the insurer agrees are essential for the rehabilitation of the insured person, and for which a benefit is not otherwise provided in this Regulation, except • services provided by a case manager, and • housekeeping and caregiver services."
ss. 17(1)(b) **CASE MANAGEMENT**	For accidents on or after June 1, 2016, but subject to subsection (2), the insurer is now required to pay for case manager services if optional medical, rehabilitation and attendant care benefits under paragraph 4 of subsection 28(1) or a CAT benefit under paragraph 5 of subsection 28(1) are available to the insured.
s. 18(3) **MEDICAL, REHABILITATION, AND ATTENDANT CARE LIMITS**	For accidents on or after June 1, 2016, insurers are not liable to pay more than $65,000 for all medical, rehabilitation and attendant care benefits (COMBINED) to those insureds who sustain an accident-related impairment that falls outside the $3,500 limit under the Minor Injury Guideline (MIG), and are not liable to pay more than $1,000,000 combined for those benefits to those insureds who meet one or more of the new CAT definitions in section 3.1(1). There are also wording changes under ss. 18(4) and 18(5) to make inclusive the new combined wording under ss. 18(3) – (5), and clarify "medical and rehabilitation benefits" with "medical, rehabilitation and, where applicable, attendant care benefits."
s. 19(3)	Legislative response to *Henry v. Gore* has been embodied in this newly worded subsection: • For accidents on or after June 1, 2016, insurers are not liable to pay more than $3,000 per month of Attendant Care benefits if an insured has not sustained a CAT impairment, or more than $6,000 per month where the insured has sustained a CAT impairment as a result of an MVA, but optional benefits have not been purchased under section 28 by the insured (ss. (3) 1); • Where optional benefits have been purchased and apply to the insured under paragraph 3 of section 28(1), the amount payable is still limited to $3,000 for monthly Attendant Care (ss.(3) 2);

	• Where optional benefits have been purchased and apply to the insured under paragraph 4 or paragraph 5 of section 28(1), the amount payable is limited under section 28(7) to $6,000 for monthly Attendant Care (ss.(3) 3); • Despite the above, if the "attendant care provider" did not ordinarily engage in such care for remuneration in the course of their employment, occupation or profession, the amount of the attendant care benefit payable is deemed not to exceed the amount of the economic loss sustained by the attendant care provider during the period while providing such care (ss. (3) 4); AND • Despite the above, if the "attendant care provider" did provide such care and the actual expenses incurred are lower than the amount of the monthly attendant care benefit, the insurer is deemed to be liable to pay only the incurred expenses (ss. (3) 5). The last two of the above provisions effectively overrule *Marcus v. TTC*
s. 20 **TEMPORAL LIMITS**	10 year temporal limit for payment of medical, rehabilitation and attendant care benefits to insureds who have not sustained a CAT impairment as a result of an MVA, or who have not purchased optional benefits under paragraph 4 or paragraph 5 of ss. 28(1), has been reduced to 5 years (ss.(2)); however, this period is extended to age 28 for insureds who were less than 18 at the time of the MVA (ss. (1)).
s. 28(1) **OPTIONAL BENEFITS**	Subsections 28(3) – (5) have been revoked, and optional benefit limits (if purchased) have been increased in the case of medical, rehabilitation and attendant care benefits: • from $65,000 to $130,000 for insureds who have not sustained a CAT impairment as a result of an accident (ss. 3); • up to $1,000,000 if optional medical, rehabilitation and attendant care benefits are purchased "that does not limit the period of time for which expenses are to be paid by the insurer" for such benefits if the insured did not sustain a CAT impairment as a result of the MVA, and up to $2,000,000 if the insured did sustain a CAT impairment due to the MVA (ss. 4); AND • if purchased, an optional catastrophic impairment benefit for medical, rehabilitation and attendant care benefits of up to $1,000,000 if the insured sustained a CAT impairment as a result of the accident (ss. 5).
ss. 28(5) – (6)	Subsections revoked and replaced with provisions that: • include all fees and expenses for conducting assessments and examinations and preparing reports within the new section 28 limits, excepting the cost of section 44 insurer assessments, and section 7(4) accounting reports to establish the quantum of IRB payable (ss. (5)); • continue to provide that no attendant care benefit is payable if the insured's impairment falls with the MIG (ss. (6)); and

	• provide that under paragraphs 4 and 5 of s. 28(1), the maximum monthly attendant care benefit payable is $6,000, and medical and rehabilitation benefits payable in respect of an insured include any amount paid for services performed by a qualified case manager authorized under s. 17 (ss. (7)).
ss. 30(3) – (4) **INDEXATION**	Subsections revoked and replaced with new provisions that provide for annual indexation options for IRB, NEB, M/R and ACBS in keeping with the other new amendments under O. Reg. 251/15 (the reader is referred to the specific new provisions for further information).
ss. 38(2)(c) **MEDICAL BENEFITS PROCEDURE**	Subsection revoked and replaced with provisions that remove the open-ended obligation of insurers to pay for emergency medical services: • drugs are deemed reasonable and necessary expenses as a result of an accident-related impairment if they are prescribed by a regulated health professional (ss. (2)(c)(i)), or • the goods referred to in clauses 15(1)(d) – (f) and 16(3)(h) – (j) if the cost is $250 or less per item (ss. (2)(c)(ii)); or • the insurer agrees that the expense is essential for the insured's treatment or rehabilitation for goods or services referred to the above clauses with a cost of $250 or less per item or service, as the case may be (ss. 2(d)).
ss. 38(3)(c)	Subsection amended to require health care providers to state in an OCF-18 that for accidents before September 1, 2010, the proposed expenses are reasonable and necessary for the insured's treatment or rehabilitation.
s. 38	Section amended to include a new subsection – 38(8.1) – which obliges an insurer to provide notice to the insured where the insurer has not agreed that goods and services referred to clauses 15(1)(d) – (f) and 16(3)(h) – (j) are essential.
ss. 39(2)(d) - **PAY PENDING DISPUTE**	Subsection revoked and replaced with a requirement on the insurer to pay the expense pending resolution of the dispute of whether an expense under subsection 15(1) or 16(3) is reasonable and necessary, or whether an expense is essential for the purpose of clauses 15(1)(d) – (f) and 16(3)(h) – (j).
ss. 40(8)(a)	Subsection revoked and replaced with new wording that deems medical and rehabilitation benefits under sections 15 and 16 to be reasonable and necessary, or essential, where a court or arbitrator determines that the MIG applies.
s. 42(11) **ATTENDANT CARE**	Wording struck out and substituting "subsection 18(3) and section 20" for the words "subject to section 20 and paragraph 2 of subsection 19(3)".

APPLICATION	
s. 42(12)	Subsection revoked and replaced with wording that enables an insurer to require an insured to undergo a section 44 assessment pertaining to attendant care entitlement only after 52 weeks have elapsed since the previous section 44 assessment relating to attendant care benefits.
s. 42(15)	Wording struck out and substituted with: "subsection 18(3) and section 20" for the words "section 20 and paragraph 2 of subsection 19(3)".
s. 42(16)	Wording amended to require insurer to give notice of a determination that insured is no longer entitled to ACBs under section 20 "after 260 weeks" rather than 104 weeks.
s.45(2) - **CAT BRAIN IMPAIRMENT**	Wording amendment from "brain impairment" to "traumatic brain impairment".
s. 45(4)	Wording amended from "104 weeks" to "260 weeks" where an insured is making a CAT application and receiving attendant care benefits immediately beforehand.
s. 45.1	**NEW PROVISION**: where an insured who is under 18 at the time of an accident occurring on or after June 1/16 is deemed to have a CAT impairment under subsection 45(6) if they sustain a traumatic brain injury meeting the criteria under ss. 3.1(5)(i) or (ii), and they need not submit an application to the insurer under subsections 45(2) – (5) as they do not apply. Effectively, in these situations, the insurer is left without any right to medically assess the insurer under section 44, or to dispute a CAT designation.
ss. 50(3)(a)-(b) and 57(4) - **BENEFIT EXPLANATION**	Wording amendment from "medical and rehabilitation benefits" to "medical, rehabilitation and attendant care benefits".
ss. 50(3)(d)	Wording revoked, with substitution of the words: "(d) the amount paid to the date of the benefit statement in respect of medical and rehabilitation benefits;"
s. 68 **TRANSITIONAL**	Paragraphs 2 and 3 amended by striking out "subsection 28(1)" and substituting "subsection 28(1) as it read immediately before O. Reg. 251/15 came into force".

PROVISIONS	