EXECUTIVE SUMMARY

The paper below sets out Unifund Assurance's proposals for the legislative review of *The Insurance Act*, R.S.O. 1990 c.I.8 as amended.

In short we propose the following revisions:

1. remove the deductible, or at least the "vanishing" aspect;
2. add a definition of incurred to the SABS;
3. limit the age and number of claimants of housekeeping/home maintenance;
4. establish a timeline for deemed approvals;
5. increase response times for treatment and assessments;
6. allow for denial of substantially similar treatment plans and requests for assessments without examination;
7. make exam cancellation fees the responsibility of the claimant unless reasonable explanation is given and accepted by the insurer;
8. eliminate rebuttal reports;
9. eliminate non-earner benefit, or at least strengthen the test;
10. eliminate or reduce the prohibition on settlement;
11. revise the PAF to limit all specified benefits, exclude collateral benefits usage and include psychological treatment;
12. redefine catastrophic impairment;
13. limit re-elections; and
14. limit the exclusion of motor vehicle accidents by collateral benefit providers.

BODILY INJURY

Deductible

In our view the deductible is merely creating inflationary pressure on the damage awards being given out by arbitrators and judges. They are simply adding the deductible value to what they have determined to be a fair award. Therefore, we propose the deductible be removed altogether or at least the "vanishing" component be removed. The vanishing aspect impairs a realistic appraisal of the value of a Plaintiff's case – Plaintiff counsel are artificially inflating the claim in order to reach the $100,000 threshold.

STATUTORY ACCIDENT BENEFITS

Add Definition of "Incurred"

Currently there is no definition of "incurred" in the SABS. This led to the decision in *Belair* v. *McMichael* where an insured was awarded attendant care expenses when the services were not provided. Therefore, we recommend the addition of the following definition of incurred - "means the service have been provided either for compensation, in anticipation of compensation, or gratuitously".

Housekeeping and Home Maintenance – Claimant and Age Limits

Currently s.22 provides coverage for "reasonable & necessary additional expenses incurred by or on behalf of insured person" to a maximum of $100 per week for 104 weeks (unless catastrophically injured).

We propose a limit on the number of persons per household who can claim this benefit and any given time. We currently see claims where we are compelled to assess 3 or more people for housekeeping in one household. We would recommend the addition of s.22(2.1) "No payment is required under this section for more than two persons per household."

We also propose an age limitation be added to this section as we are currently seeing claims for very small children. We would recommend the addition of s.22 (2.2) "No payment is required under this section to insured person under 16 years of age."

Approval Timeline

Currently when an OCF-22 or OCF-18 is deemed approved due to a missed deadline, there is no timeline before which the assessment or treatment must occur. One would assume that if a medical practitioner felt an assessment or treatment to be necessary, that the period of time in which that assessment or treatment was to be carried out would be finite. We propose a timeline be placed on deemed approvals for treatment and for assessments.

The revisions necessary to accomplish this regarding deemed approvals include:

1. Adding s.38.2(9.1) "Despite subsection (9), the insurer is only obligated to pay for assessments which are carried out within 6 months of the date of submission of the request for assessment."
2. Adding s.38(8.2) paragraph 3 "Despite paragraph 2, the insurer is only obligated to pay for goods and services which are provided within 6 months of the date of submission of the treatment plan."
3. Adding to s.38(17)(a) following "report or determination" the phrase "on the condition that the goods and services are provided within 6 months of the date of submission of the treatment plan."

We also recommend the same timeline be established for all approvals as the current legislation allows for approved treatment and assessments to remain open-ended. We are particularly concerned about assessments as we have experienced gaps of more than a year between approval and implementation.

Response Times

The current timelines for response under the SABS are untenable. They do not allow enough time for an experienced adjuster to make an informed and rational decision. Simply approving or denying by default is not helpful to the insurer or to the claimant.

We recommend doubling the current timelines:

1. s.38.2(6) assessments approval/denial – to be changed to 6 days
2. s.38.2(4) conflict of interest re assessment – to be changed to 4 days
3. s.38(8.1)(a) OCF-18 approval/denial – to be changed to 20 days
4. s.38(8.1)(b) OCF-18 approval/denial where PAF – to be changed to 10 days
5. s.37.1(5), s.37.2(3) approval (partial or full) of OCF-23 – to be changed to 10 days

In the alternative, we propose that a maximum limit be placed on the number of OCF-18s or OCF-22s that are submitted per claimant in a defined period. We feel the current deadlines set up a perfect environment for abuse. While we acknowledge the need for assessments and treatment, we do not see how any one person could possibly need decisions on 5-10 assessments in one day. We recommend a limit of 3 Ocf-18 and 22s, inclusive, be submitted per 3 day period. We are unclear as the placement of this revision in the legislation but feel it is a reasonable compromise to help avoid flooding the adjuster with paperwork in the hopes of something being approved by default.

Substantially Similar Treatment Plans and Assessments

Currently s.42(3) paragraph 3 states that only a paper review is required when the goods or services are "substantially similar to goods or services the insurer previously refused to pay for when they were included in a previous treatment plan submitted to the insurer on behalf of the insured person in respect of the same accident". We propose that in this situation no examination of any kind be required unless 6 months has passed since the denial of the substantially similar treatment plan.

Further, we propose that when a substantially similar request for assessment is submitted, that no examination is required for denial unless 6 months has passed since the denial of the substantially similar request for assessment.

Examination Cancellation Fees

Currently, these fees are paid by insurers regardless of the reason for the cancellation. We have had experiences where the claimants have been advised by their representative not to attend examinations for legal reasons and no notice has been provided to the insurer. We recommend a section be added to the SABS which indicates that unless a reasonable explanation is provided, that these fees will be the obligation of the claimant.

Rebuttal Reports

Section 42.1 should be repealed. These assessments after denials are not useful and are a source for abuse, only adding extra expense to the claims process and no benefit to the claimant.

Non-Earner Benefits

We propose this benefit be abolished. Paying a person a weekly benefit that did not exist before the loss goes against the rule of indemnity.

Settlement of Claims

Currently s.9.1(10) of Ontario Regulation 664 places a restriction on an insured person's right to mediate, litigate, arbitrate, appeal or apply to vary, etc. before the first anniversary from the date of loss. This section effectively places a prohibition on settlement during the first year after the date of loss because even if agreement was made on settlement, it would not be binding.

In our view this restriction is encouraging claimant representatives to prolong claims that could and should have resolved before the one-year mark. We propose this prohibition on settlement be removed or in the alternative, be shortened to 6 months.

Pre-approved Framework Guidelines

Currently the Pre-Approved Framework Guideline limits entitlement to income replacement benefits to 12 or 16 weeks. We propose this limitation also be extended to all Specified Benefits.

As well we propose that, as an incentive to utilize the PAF, that claimants receive coverage for all PAF treatment without having to access their extended healthcare coverage.

We propose that psychological counselling be added to the PAF, with the requisite increase in fees.

Definition of Catastrophic Impairment

We understand that Dr. Lacerte (and perhaps others) has been asked to review the definition of catastrophic impairment in the SABS. Therefore, we will be brief and limit our proposal to recommend that the legislation be revised to clarify that the 55% whole person impairment test is limited to physical findings.

Elections

We propose adding a limitation on re-elections. Currently the claimant can re-elect between Specified Benefits at any time. This would be controlled by adding s.36(4) "If a person requires a re-election to select a different Specified Benefit that the one selected under subsection (2), they must provide a reasonable explanation for this and they must receive the consent of the insurance company or, in the event of dispute, the right to do so will be determined by mediation."

Other Collateral Benefits

The language of s.60 could be revised to confirm the primacy of collateral benefits to SABS benefits.

Currently s.60(2) reads: "Payment of a medical, rehabilitation or attendant care benefit or a benefit under Part VI is not required for that portion of an expense for which payment is reasonably available to the insured person under any insurance plan or law or under any other plan or law." We propose this language be made more specific in order to override those collateral benefits policies that exclude motor vehicle accidents.