

## **DACs To Be Eliminated March 2006**

The Liberal government at Queen's Park has filed a new regulation, following through on its promise to eliminate Designated Assessment Centres (DACs). The Regulation (O. Reg. 546/05), filed last Friday, takes effect on March 1, 2006.

The new Regulation will eliminate DACs and replace them with Insurer Examinations conducted by health care practitioners selected specifically by the insurer to resist the recommendations made by an injured person's treating health care professional for benefits. However, the new rules provide little means for the injured person to challenge the Insurer Examination where they are not satisfied with the findings of the Insurer's expert.

At the same time, the new regulation puts additional burden on injured people by requiring them to provide multiple forms and other documents, virtually at the whim of the insurance company. The failure to provide the documents within the short times enumerated will be to the detriment of the injured party. Given the complexity of the regulation, it is going to be very difficult for most injured people to comply with its requirements, enhancing the already superior position held by the insurance industry and the great disparity of bargaining power between insurers and injured people.

While those of us who are interested in the rights and welfare of accident victims have promoted the elimination of DACs, it is most unfortunate that the insurance industry has substantially influenced these reforms. The rich and powerful insurance lobby has persuaded the government to include changes that further complicate the process for accessing benefits, and work to the detriment of injured people.

It was hoped that removing the DAC process would achieve a substantial savings in expense. These savings could have been used to keep premiums down and to restore some of the rights that were taken from innocent accident victims by previous reforms. Instead, what we have is a densely worded amendment that significantly increases the insurer's right to have injured people medically examined by the insurance company's doctor of choice, intended only to support a denial of benefits recommended by the injured person's own treating health care practitioners.

Meanwhile, the ability of the injured person to respond to the insurance company's medical expert is so limited as to be virtually meaningless. As a result, the power of the insurance company will be enhanced, at the expense of the accident victim, in a system that already heavily favours the insurer. Additional hurdles to access benefits have again been placed in the way of accident victims.

Any suggestion of impartiality in the assessment process vanishes entirely with the substitution of insurer controlled examinations for DACs. The government had promoted the notion that more attention ought to be paid to treating practitioners, those with a long-standing relationship with the injured person and appreciation for the injured person's health issues. Instead, the new amendments take a giant step away from that important objective.

The insurance industry is motivated by the single goal to achieve maximum profitability for its shareholders. It is clear that, for our elected officials, the fear of political fall-out from the spectre of higher premiums results in capitulation to the

demands of the insurance industry. In the meantime, those who promote the interests of consumers and accident victims do not get an adequate hearing.

At the same time, each and every reform to auto insurance promoted by the insurance industry and adopted by the government has resulted in added complexity and further erosion of the rights of consumers and accident victims. The insurance industry bureaucracy that inevitably must grow around these changes is paid for by premiums from the driving public. Insurers continue to enjoy huge profits, while accident victims get less and less.

Elimination of DACs was motivated primarily by the desire to save the substantial expense associated with the DAC process. Incredibly, the increase in Insurer Examinations, in lieu of DACs, will mean very little savings. One may wonder, therefore, why the insurance industry is so keen to see DACs gone if little in savings can be achieved. The answer is that it will dramatically enhance the ability of the insurance industry to resist claims by injured people. This will result in savings. The net effect for auto insurance is that more and more will be spent on medical personnel doing Insurer Examinations, the only goal of which is to deny payment to an injured person, while less and less will go to accident victims.

Below are some highlights from the amending regulation (Ontario Regulation 546/05):

1. The changes are effective March 1, 2006;
2. Disability Certificates must include a statement by the health care practitioner stating the cause and nature of the impairment and an estimate of the duration of disability (section 2(1));
3. The insurer can demand multiple Disability Certificates from the injured person which must be delivered within 15 days of the request, failing which the benefit payment will be suspended;
4. Health care professionals doing Insurer Examinations (section 42) can consult with treating professionals who will be paid by the insurer for up to a 30 minute consultation (section 24(1)9);
5. The notice requirements under section 32 (within 7 days for accidents occurring after September 30, 2003) still apply. Failure to comply, without reasonable explanation, allows the insurer to delay paying benefits for up to 45 days after the insurer gets the application or 10 business days after the insured person has complied with a request for information or examination under oath, whichever is later;
6. Insurers are now entitled to do "Pre-Claim Examinations" under new section 32.1. These examinations can take place, with the consent of the injured person, while in hospital or within 3 days after discharge to determine if the person is entitled to a benefit. These examinations take place before application has been made for a benefit. Even if it is found that the person requires a benefit, there is no obligation to pay until application is made and a disability certificate filed. The report generated cannot be relied on by the insurer is making a determination that the person is not entitled to a benefit;
7. Applications for income replacement benefits, non-earner benefits and housekeeping benefits must be accompanied by a disability certificate that was completed no earlier than 10 business days before application has been made (see section 35). Refusal to pay these benefits can be justified in a number of ways, including where the injured person fails to provide forms or

- information required under the regulations or where the decision is justified based on an Insurer Examination (section 42).
8. The benefits referred to in item 7 above (called "specified benefits") can be discontinued in accordance with the provisions of section 37. The denial process starts with a request for a new Disability Certificate, likely followed by a section 42 Insurer Examination. Other than for non-compliance with the technical requirements of the regulation, the benefit can be stopped if not supported by the section 42 examiners;
  9. Again with respect to specified benefits set out in item 7 above, where a Disability Certificate has been requested and not supplied, no benefit is payable between 15 days after the request for a Disability Certificate and the day the Certificate is finally provided (section 37(3)). Failure to submit to the Insurer Examination also suspends benefits until the person submits to the examination and provides the required information (section 42(10)), though the insurer must pay the benefits withheld if the injured person has a reasonable excuse for late compliance (section 37(8));
  10. An application for Attendant Care must be in the form of an assessment of attendant care needs which can be found on the FSCO website (section 39);
  11. Under section 39 the insurer must pay the attendant care benefits within 10 business days of receiving the assessment form, pending a section 42 Insurer Examination if requested;
  12. Where the insurer later wants to question the amount of or entitlement to attendant care, a new assessment can be requested and must be provided within 10 business days from the request (section 39(5)). In the meantime, and pending a section 42 Insurer Examination, payment of the attendant care benefit must continue;
  13. For catastrophically injured people entitled to attendant care benefits for more than 104 weeks, request for new assessments and section 42 Insurer Examinations cannot take place more than once a year (section 39(10));
  14. Transitional Rules are set out in section 41.1. Continued entitlement to income replacement benefits, no-earner benefits and caregiver benefits will be determined in accordance with the new rules after February 28, 2006;
  15. Insurer Examination rights are expanded under section 42. The insurer can insist on an examination as often as is reasonable necessary to determine if an injured person is entitled to or continues to be entitled to a benefit. The insurer has the right to determine the examiner or examiners. Section 42(10) imposes an obligation on the injured person to supply, within 5 days of receiving notice, to provide to the persons conducting the examinations "all reasonably available information and documents that are relevant and necessary for the review of the insured person's medical condition".
  16. There is some limited ability for an injured person to have a health care professional respond to adverse findings by an Insurer Examination under section 42.1. The person responding, with some exceptions, must be the "original provider" (i.e., the person who completed the treatment plan if that is the matter in issue). The assessment is limited to that portion of the report with which the person takes issue. The report must be delivered to the insurer within 40 days after the insurer gave notice of its determination (or 80 days in the case of catastrophic determination).
  17. The amount an insurer will pay is very limited under section 42.1. The language of section 42.1(8) is very unclear, but it appears that the maximum payable would be for a medical doctor who is a specialist in the amount of \$900.

This summary is only intended to provide a few of the highlights of the amending regulation. For more detailed information, please see:

[http://www.ontarioinsurance.com/english/pubs/bulletins/autobulletins/2005/a-08\\_05.asp](http://www.ontarioinsurance.com/english/pubs/bulletins/autobulletins/2005/a-08_05.asp)

Richard Halpern  
Thomson Rogers  
Director  
OTLA Insurance Committee