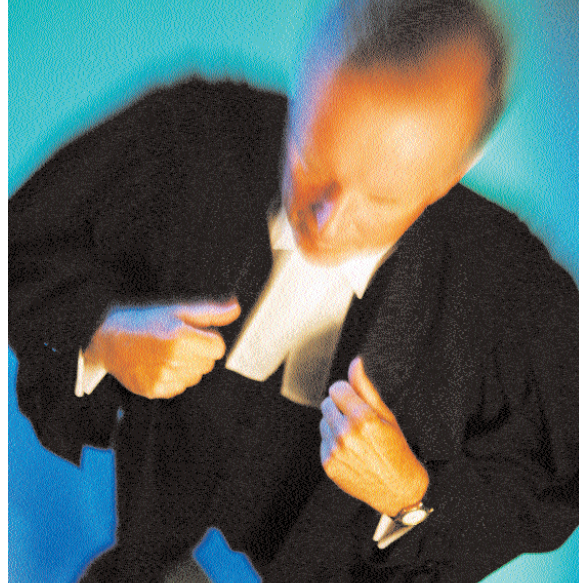


## ALBERTA INSURANCE REFORM LEGISLATION



INSURANCE LITIGATION LEGAL ALERT OCTOBER, 2004

### A REVIEW OF BILL 53, THE INSURANCE AMENDMENT ACT, 2003 (No. 2), S.A. 2003, c.40

In November of 2003 the Provincial Government of Alberta tabled legislation aimed at reforming the auto insurance industry. The claimed reasoning for the new legislation was a demand by Albertans for more affordable auto insurance premiums. Bill 53, the *Insurance Amendment Act*, 2003, was passed very quickly receiving First Reading on November 26, 2003 and Third Reading December 3, 2003.

The most significant changes to the *Insurance Act* as a result of the *Insurance Amendment Act* are summarized below.

#### 1. MINOR INJURY REGULATION

##### A. CAP FOR MINOR INJURIES

One of the most significant changes to come out of Bill 53 is the cap on damages awards for minor injuries. The new section 650.1 of the *Insurance Act* provides that the amount recoverable as damages for non-pecuniary loss of a plaintiff for a minor injury must be determined in accordance with the regulations.

The new *Minor Injury Regulation* sets a cap of \$4,000 for non-pecuniary loss for minor injuries. It also defines what is to be considered a minor injury.

##### B. MINOR INJURY

The definition for minor injury provided by the *Minor Injury Regulation* is as follows:

Minor injury, in respect of an accident, means a

- “sprain” –an injury to one or more of the tendons or ligaments, or both;
- “strain” –an injury to one or more muscles; or a
- “WAD injury” a Whiplash Associated Disorder other than one that exhibits one or both of the following:
  - (a) objective, demonstrable, definable and clinically relevant neurological signs;
  - (b) a fracture to or a dislocation of the spinecaused by that accident that does not result in a serious impairment. [s. 1(h)]

##### C. SERIOUS IMPAIRMENT

Serious impairment is defined as an impairment of a physical or cognitive function that results in a substantial inability to perform the

- essential tasks of the claimant’s regular employment, occupation, profession, despite reasonable efforts to accommodate;
- essential tasks of the claimant’s training or education in a program or course that the claimant was enrolled in or had been accepted for enrolment in at the time of the accident, despite reasonable efforts to accommodate; or
- normal activities of the claimant’s daily living, that has been ongoing since the accident and that is not expected to improve substantially. [s. 1(j)]

This definition of minor injury was developed by the government through consultation with organizations representing injured people, insurers, lawyers and health care providers. It would appear to provide fertile ground for litigation including “essential tasks”, “efforts to accommodate” and “normal activities of daily living”.

#### **D. DEFENDANT INCLUDES INSURER**

“Defendant” means a person against whom an accident claim is made or may be made and includes that person’s insurer. In other words, an insurer may now engage all of the provisions in the minor injury regulation well before any action is commenced. [s. 1(g)]

#### **E. INJURY MUST BE “PRIMARY FACTOR”**

In assessing serious impairment, the injury must be the “primary factor” contributing to the impairment. This is an attempt to legislate out of existence the causation test set out in *Athey v. Leonati* [1996] 3 SCR 458. *Athey* provides that compensable injuries need only “materially contribute” to the claimant’s post-accident condition. Imaginative counsel will no doubt test the scope of this provision.

#### **F. PROTOCOLS NOT FOLLOWED / FAILURE TO MITIGATE**

If the claimant, without reasonable excuse, fails to be diagnosed and treated in accordance with the *Diagnostic and Treatment Protocols Regulation*, then even if the claimant has sustained an injury that results in serious impairment (i.e., a “non-minor” injury), he will be treated as if he sustained a minor injury and will be entitled to no more than \$4,000 in non-pecuniary damages. However, it is open to the claimant to attempt to prove that his non-compliance with the protocols made no difference to his condition. [s. 5]

#### **G. PREVIOUS MEDICAL CONDITION**

The claimant’s previous medical condition is to be considered when determining if a serious impairment has been sustained. As such, a claimant is less likely to avoid the cap if he has:

- a pre-existing condition which has been aggravated;
- symptoms which are primarily attributable to a prior or subsequent tort or other cause. [s. 4(3)]

#### **H. MULTIPLE INJURIES**

Each injury must be assessed to determine if it constitutes a minor injury. The injuries are then divided into minor and non-minor categories. Minor injuries, collectively, are valued to a maximum of \$4,000 total. Should a “non-minor” injury be coupled with one or more minor injuries, damages for non-pecuniary loss for all injuries sustained by the claimant will be determined in the following manner:

- (a) if the non-minor injury or injuries, when assessed separately from the minor injury or injuries, would result in an award for non-pecuniary loss of not more than \$4000, the total amount recoverable as

damages for non-pecuniary loss for all injuries sustained by the claimant shall not exceed \$4000;

- (b) if the non-minor injury or injuries, when assessed separately from the minor injury or injuries, would result in an award for non-pecuniary loss of more than \$4000, the total amount recoverable as damages for non-pecuniary loss for all injuries sustained by the claimant shall be calculated as the total of
  - (i) the amount of damages assessed for non-pecuniary loss for the non-minor injury or injuries, and
  - (ii) subject to section 6, the amount of damages assessed for non-pecuniary loss for the minor injury or injuries. [s. 7]

#### **I. CERTIFIED EXAMINER (CE)**

No attempt can be made to characterize the injury as “minor” or otherwise until at least 90 days post-accident. [s. 8(7)]

At any point once 90 days has passed any party can give notice of their intention to have a CE assess the claimant for an opinion as to whether the injury is or is not “minor”. The notice is to specify the name of the proposed CE. The other party can accept or reject the proposed CE. If no rejection comes within 14 days, the proposed CE is deemed accepted. If the parties cannot agree on a CE the Superintendent will select one within five days. [s. 8(1-6)]

#### **J. QUALIFICATIONS**

CEs must be medical doctors. They must also fulfill the following criteria:

- (a) be an active practising member under the Medical Profession Act,
- (b) have successfully completed an examination approved by the council for admission as a certified examiner,
- (c) have demonstrated to the satisfaction of the council that the physician
  - (i) is knowledgeable with respect to the biopsychosocial model,
  - (ii) is knowledgeable with respect to assessing acute and chronic pain,
  - (iii) is knowledgeable in the application of the International Classification of Diseases,
  - (iv) is experienced in rehabilitation and disability management,
  - (v) is competent in conducting independent assessments and providing third party opinions, and
  - (vi) uses evidence-based decision-making in the physician’s practice. [s.16]

Only one assessment may be ordered. [s. 8(7)] The CE cannot have treated the claimant, and cannot have been consulted by the insurer. The CE must make reasonable efforts to see the claimant within 30 days of the referral, and within 30 days thereafter must provide his opinion. No “battle of the experts” takes place at this stage of the proceeding.

## **K. COMPLIANCE**

In assessing whether the injury is minor, the CE may compel the claimant to produce any records he considers relevant to the inquiry, including any relevant diagnostic, treatment or care information, and may receive from the claimant or the insurer any information that either party considers relevant to the assessment. [s. 10]

If the CE cannot provide an injury opinion in the first instance, he may require the claimant to re-attend on a specific date but not later than 6 months after the first assessment. [s. 11]

The claimant's injury will be deemed to be "minor" if without reasonable excuse the claimant in any way obstructs the CE's assessment. [s. 10(3)]

## **L. PRIMA FACIE EVIDENCE**

The opinion of the CE is *prima facie* evidence that the claimant's injury is or is not a minor injury, as the case may be [s. 12]. This will undoubtedly lead to disputes over the weight to be given to contrary opinions if litigation is commenced.

## **M. COST OF CE ASSESSMENT**

The cost of the CE shall be paid by the party requesting the assessment. [s. 13]

## **N. TEST FOR DETERMINING IF CLAIMS CAP APPLIES [S. 4]:**

1. Is the alleged injury confined to a strain, sprain or WAD injury?
  - The cap will not apply if the injury is a fracture, dislocation, neurological impairment or other injury.
2. If yes, is it a minor injury?
  - The cap will not apply if the injury has produced a "substantial inability" to perform the "essential tasks" of a claimant's employment, training, or education, or their "normal" daily activities.

The *Minor Injury Regulation* [s. 4(2)] provides that the determination as to whether an injury is a sprain, strain or WAD injury must be based on an individual assessment of the claimant in accordance with the diagnostic protocols established under the *Diagnostic and Treatment Protocols Regulation*.

## **2. DIAGNOSTIC AND TREATMENT PROTOCOLS REGULATION**

The *Diagnostic and Treatment Protocols Regulation* outlines how a patient is to be diagnosed and treated in accordance for a sprain, strain or WAD injury caused by a motor vehicle accident. These protocols are to "help" health care practitioners to provide appropriate and consistent treatment. The regulation defines health care practitioners as including: physicians, registered members as defined in *The Chiropractic Profession Act* and physical therapists as defined in the *Physical Therapy Profession Act*. Injured victims will not have to wait for approval from their insurance company before receiving treatments. These assessments will not be performed by the patient's family doctor, but rather a new group of doctors paid for from a pool of money from insurers.

Not all MVA injuries are caught by the new protocols. The WAD injury as defined above includes WAD I and II whiplash. The more serious WAD III and IV injuries are not covered by either regulation. Also, injuries other than sprains, strains and WAD injuries are outside of either regulation. These may include chronic pain, fibromyalgia, myofascial (regional) pain, depression, post traumatic stress disorder, and TMJ, amongst others.

#### **A. STRAINS AND SPRAINS – EVIDENCE-BASED PRACTICE**

When assessing a strain/sprain injury the health care practitioner must employ the *International Classification of Diseases* and “evidence-based practice” when taking a history (which must include “the client’s relevant past history, including physical, psychological, emotional, cognitive and social history”) and perform a physical examination including a ‘pain assessment’.

The *International Classification of Diseases* means the most recent edition of the publication titled the *International Statistical Classification of Diseases and Related Health Problems*, Canada, published by the Canadian Institute of Health Information, based on a publication issued from time to time titled the *International Statistical Classification of Diseases and Related Health Problems*, published by the World Health Organization.

“Evidence-based practice” is defined in the regulations as the conscientious, explicit and judicious use of current best practice in making decisions about the care of a client, integrating individual clinical expertise with the best available external clinical evidence from systematic research. It is a relatively new approach to medical diagnosis and treatment. [s. 1(b)]

The regulations do not set out precisely how the *International Classification of Diseases* or “evidence based practice” is to be employed.

#### **B. STAIN / SPRAIN SEVERITY**

If a strain or sprain is diagnosed, its severity will be assessed on the basis of a scheme set out in the publication *Orthopaedic Physical Assessment* by David J. Magee, (3rd), (1997), at page 19, and reproduced in the Regulations. [ss. 7(2), 11(2)]

#### **C. STRAIN / SPRAIN TREATMENT**

If a strain / sprain is diagnosed, it is to be treated by:

- (a) educating the client with respect to at least the following matters:
  - (i) the desirability of an early return to normal activities and to work, if applicable;
  - (ii) an estimate of the probable length of time that symptoms will last;
- (b) managing inflammation and pain, as required,
  - (i) by the protected use of ice;
  - (ii) by elevating the injured area;
  - (iii) by compression;
- (c) teaching the client about maintaining flexibility, balance, strength and the functions of the injured area;
- (d) giving advice about self?care and the disadvantage of extended dependence on health care providers;

Providing otherwise acceptable treatment in the health care practitioner’s opinion that is necessary for the claimant’s rehabilitation and continued clinical improvement. [ss. 8, 12]

#### **D. NUMBER OF TREATMENTS**

Without the need for approval by the insurer, a health care practitioner may authorize up to 11 visits in total for a 1st or 2nd degree strain or sprain, together with certain diagnostic tests and medications and supplies. The 11 visits are for the total of “medical, physical therapy, chiropractic and adjunct therapy” visits. For a 3rd degree strain or sprain, no more than 22 visits in total are to be authorized. [ss. 9, 12]

## **E. WHIPLASH ASSOCIATED DISORDER (WAD) INJURIES**

The diagnosis of whiplash injuries is to be guided by the Quebec Task Force on whiplash rather than the *International Classification of Diseases* and again by the use of “evidence-based practice”. A health care practitioner must take a history similar to that set out above for strains and sprains, including “the client’s relevant past history, including an “inquiry into alerting factors that may influence prognosis”. The expression “alerting factors” is not defined.

## **F. DIAGNOSIS – WAD I**

A WAD I injury will be diagnosed when there are:

- (a) complaints of spinal pain, stiffness or tenderness;
  - (b) no demonstrable, definable and clinically relevant physical signs of injury;
  - (c) no objective, demonstrable, definable and clinically relevant neurological signs of injury;
- no fractures to or dislocation of the spine. [s. 16]

## **G. TREATMENT – WAD I**

If a WAD I injury is diagnosed, no further investigation of the injury is warranted unless cause is shown. A WAD I injury will be treated by:

- (a) educating the client with respect to at least the following matters:
  - (i) the desirability of an early return to normal activities and to work, if applicable;
  - (ii) an estimate of the probable length of time that symptoms will last;
  - (iii) reassurance that there is likely no serious currently detectable underlying cause of the pain;
  - (iv) the importance of postural and body mechanics control;
  - (v) that the use of a soft collar is not advised;
  - (vi) the probable factors that are responsible for other symptoms the client may be experiencing that are temporary in nature and that are not reflective of tissue damage, including
    - (A) disturbance of balance,
    - (B) disturbance or loss of hearing,
    - (C) limb pain or numbness,
    - (D) cognitive dysfunction, and
    - (E) jaw pain;
- (b) giving advice about self-care and the disadvantage of extended dependence on health care providers;
- (c) prescribing medication, including the appropriate use of analgesics, which may include short-term use of non-ovoid analgesics or non-steroidal anti-inflammatory drugs, but muscle relaxants and narcotics are not authorized under these protocols for treatment of WAD I injuries;
- (d) in the case of treatment of an injury,
  - (i) pain management, as required;
  - (ii) injury specific exercises;
  - (iii) early return to normal activities;
  - (iv) a home exercise program to improve range of motion;

- (v) thermal therapy by the client;
- (vi) preparing the client for a return to work, if appropriate;
- (e) providing otherwise acceptable treatment in the health care practitioner's opinion that is necessary for the claimant's rehabilitation and continued clinical improvement. [s. 17]

#### **H. NUMBER OF TREATMENTS – WAD I**

As with strains or sprains, without insurer approval the health care practitioner may authorize up to 11 visits in total for a WAD I injury, together with certain diagnostic tests and medications and supplies. The 11 visits are for the total of “medical, physical therapy, chiropractic and adjunct therapy” visits. [s. 18(2)]

#### **I. DIAGNOSIS – WAD II**

A WAD II injury will be diagnosed when there are:

- (a) complaints of spinal pain, stiffness or tenderness;
- (b) demonstrable, definable and clinically relevant physical signs of injury, including
  - (i) musculoskeletal signs of decreased range of motion of the spine, and
  - (ii) point tenderness of spinal structures affected by the injury;
- (c) no objective, demonstrable, definable and clinically relevant neurological signs of injury;
- (d) no fracture to or dislocation of the spine.

Unlike a WAD I injury, an investigation to determine a WAD II injury and to rule out a more severe whiplash injury may include x-rays in the manner prescribed in the regulations. However, no MRI or CT scan will be authorized unless three plain x-rays are equivocal. [s. 19]

#### **J. TREATMENT – WAD II**

A WAD II injury will be treated in essentially the same manner as a WAD I injury, with the exception that, for WAD II, s.20(d)(v) of the regulation specifically mentions “initiation of manipulation, manual therapy of mobilization, or any 2 or more of them, to improve function, if appropriate”. [s. 20]

#### **K. NUMBER OF TREATMENTS – WAD II**

For a WAD II injury a health care practitioner may authorize no more than 22 visits in total, together with certain diagnostic tests and medications and supplies. The 22 visits are for the total of “medical, physical therapy, chiropractic and adjunct therapy” visits. [s. 21]

#### **L. STRAINS / SPRAINS / WAD INJURY TREATMENT LIMITS AND REFERRALS**

Generally, no more than 11 or 22 treatments will be authorized for multiple injuries that otherwise fall within the definitions of sprains, strains or WAD I or II injuries. [s.22]

The health care practitioner's authorization for anything permitted by the protocols must be in writing and issued within 90 days of the date of the accident. The authorization expires 90 days after the date of the accident unless approved by the insurer for a longer time. [s.22]

#### **M. INJURY MANAGEMENT CONSULTATION**

Within the first 90 days post-accident a health care practitioner may authorize a visit by a client to an injury management consultant if the health care practitioner:

- (a) is uncertain about an injury to which the protocols apply or the diagnosis or treatment of it;
- (b) believes that the injury
  - (i) is not resolving appropriately, or
  - (ii) is not resolving within the time expected and the practitioner requires another opinion or report. [s. 24]

Physicians, physiotherapists, and chiropractors are injury management consultants if they meet the requirements of their own profession, including that they are “an active practising member of that person’s profession”, and that they have demonstrated to the satisfaction of the council of that person’s profession that he or she:

- (i) is knowledgeable with respect to the biopsychosocial model,
- (ii) is knowledgeable with respect to assessing acute and chronic pain,
- (iii) is experienced in rehabilitation and disability management, and
- (iii) uses evidence-based decision-making in his or her practice. [s. 28]

#### **N. BIOPSYCHOSOCIAL MODEL**

The “biopsychosocial model” is not defined in the regulation. In relation to whiplash, the model proceeds on the assumption that no scientific evidence exists that WAD I/II whiplash injuries cause serious physical damage to the soft tissues that could explain chronic pain. There is some debate whether psychosocial factors predict injury outcomes. The biopsychosocial model is virtually unknown in Alberta case law.

#### **O. “ALERTING FACTORS”**

With regard to diagnosed WAD I or WAD II injuries, if the client has any ‘alerting factor’ that may influence prognosis, the health care practitioner must seek to reassess the client within 21 days of the accident. If the injury is not resolved, the health care practitioner must refer the client to an injury management consultant for an assessment and report. The authorization for one such visit is in addition to the 11 or 22 visits otherwise permitted. [s. 24(2)]

#### **P. INJURIES UNRESOLVED AFTER 90 DAYS**

If after 90 days post-accident a sprain, strain, or WAD I/II injury has not resolved or is not satisfactorily resolving, then subject to the insurer’s approval the health care practitioner may refer the client to an injury management consultant (IMC). The IMC may report on the diagnosis or treatment of the client, or recommend a further assessment or a multi-disciplinary assessment of the injury, and the persons who should be included in the assessment. [s. 25]

The insurer must approve the involvement of an IMC at this stage, and must approve the recommended treatment plan, if any. The regulations are silent regarding disputes that may arise if the insurer refuses payment. The regulation is unclear as to whether the insurer can initiate the involvement of the IMC, or seek its own IMC, or other medical opinion in rebuttal.

#### **Q. CLAIMS AND PAYMENT OF CLAIMS**

Within 10 business days of a motor vehicle accident or as soon as is practicable the client or his health care practitioner must provide to the insurer a completed claim form including detail of the accident and injuries [ss. 32-35]

Within five business days of receiving a completed form the insurer must send to the applicant a decision notice either approving or refusing the claim. The notice must give reasons for any refusal. Reasons for refusal are limited, e.g., the claimant is not an insured person under the Regulations; there is no contract of insurance; the injury was not caused by the accident arising from the use or operation of an automobile.

If the insurer fails to respond to the claim within five business days, it is deemed to have approved the claim, and is liable to pay the claim unless reasons exist for a subsequent denial of the claim.

An insurer may subsequently deny a claim in writing for essentially the same reasons set out above. [ss. 32-35]

### 3. INCREASE IN SECTION B BENEFITS

The new Automobile Accident Insurance Benefits Amendment Regulation has modified the section B benefits as follows:

| Benefit                    | Current maximum                    | New maximum |
|----------------------------|------------------------------------|-------------|
| Overall Medical Payments   | \$10,000                           | \$50,000    |
| Chiropractic treatments    | \$500                              | \$750       |
| Massage therapy            | Included with \$10,000 payment cap | \$250       |
| Acupuncture                | Included with \$10,000 payment cap | \$250       |
| Grief counselling services | Nil                                | \$400       |

Other changes:

- “Death Benefits” has been expanded to include grief counselling.
- “Head of household” benefits have been extended to an “adult interdependent partner”.

### 4. ADVANCE PAYMENTS TO INSURED

Section 636 allows regulations regarding court orders that require an insurance company to make payment to a claimant ahead of a court judgment. No such regulation has yet been passed.

### 5. STRUCTURED JUDGMENTS

The new section 650.2 allows for regulations regarding court orders that require the insurance company to make structured settlements on terms the court considers appropriate. No such regulation has yet been passed.

### 6. DEDUCTIONS TO DAMAGES AWARDS RELATED TO INCOME TAX

The new section 626.1 states that the amount of an award for loss of earnings will now be reduced by a sum equivalent to income tax that would have otherwise been paid on the income. The award is also reduced by contributions to Canada Pension Plan and premiums under *Employment Insurance Act* that would have been payable with respect to lost earnings before and after the award, had the accident not occurred. These three deductions will also be made from any award or portion of an award that is in payment of a head of damages to which tax, CPP deductions and/or EIA deductions are applicable. For example, disability insurance payments. This section does not apply to any accident claim that arose in respect of an accident that occurred before the coming into force of this section. [626.1(9)]

## 7. NO RIGHT OF SUBROGATION FOR DISABILITY INSURANCE

Section 626.1(6) removes the right of subrogation for disability insurers.

## 8. METHODS OF RESOLVING DISPUTES

Section 661.3 authorizes the government to issue regulations for dispute resolution where an insured can complain on various issues, including fault, as determined by the insurance company regarding an accident claim. With the dispute process an insured may challenge the fault assigned and avoid higher premiums if his or her challenge is successful. No such regulation has yet been filed and registered.

## 9. CURRENT STATUS OF BILL 53

Some sections of Bill 53 are now in force. Sections 17 and 20(a) came into force on December 4, 2003. Section 17 sets out the new section 661.1(1) which enable the government to create regulations that will freeze auto insurance premiums, and section 20(a) includes a reference to the premium freeze.

On January 26, 2004 sections 4, 6, 14, 23, 24 and 25 came into force. Section 4 replaces the current section 608, repeating the same definitions of contract and insured but containing new definitions of accident, accident claim and basic coverage. Section 6 contains the new s. 626.1 which implements the deductions to damages awards related to income tax. Section 14 makes the current s. 651(1), subrogation rights of the automobile insurer, subject to the new s. 626.1(6) where the subrogation rights do not extend to disability insurance. Sections 23 to 25 are transitional sections that prevent the application of s. 626.1 to the Hospitals Act, the Motor Vehicle Accident Claims Act, and the Workers' Compensation Act. The remaining sections of Bill 53 will come into force on October 1, 2004.

On June 21, 2004 section 18 came into force. It enacts s. 661.2, which deals with when insurance companies are deemed to be withdrawing from the business of automobile insurance.

**For more information please contact your Parlee McLaws LLP legal representative in the Edmonton office at 780-423-8500 or in the Calgary office at 403-294-7000.**

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*The Fine Print:*

*This legal alert is intended to provide general information concerning developments in the law and is not intended to provide legal advice in respect of any particular situation.*

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