

**ALBERTA AUTO INSURANCE REFORMS**  
**By Leslie C. Paetz and Kelly J. Robinson<sup>1</sup>**

The Alberta Government has unveiled its long awaited Automobile Insurance Reforms. Some key changes are already in force with the rest of them set to come into force on October 1, 2004.

**1. Amendments in force as of January 26, 2004**

Among the significant changes to the *Insurance Act* in Alberta, R.S.A. 2000, c. 1-3, are the amendments defined in the new section 626.1 which came into force on January 26, 2004. This section deals with, among other things, the issue of what many termed “double recovery”. Its intent, upon examination, is clearly to put a claimant in the same position after receiving an award (defined in the section as a judgment or settlement in respect of an accident claim) that he or she would have been in financially, had the accident not occurred. How is this done? The section’s significant points can be separated into three categories: 1) net of tax awards; 2) deduction of other benefits; and 3) elimination of subrogation.

**a. Net of tax awards**

Simply put, a claimant’s award for loss of income must be reduced by the income tax that individual would normally be obligated to pay on the amount. While insurers were formerly obligated to pay gross income losses, calculations of income awards both past and future should now be net of tax. CPP and EI payments are also deductible. This change has long been lobbied for, and will now result in fairer assessments – why should the claimant receive more in his or her pocket for earnings relating to a motor vehicle accident than he would have been received in the normal course?

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### **b. Deduction of other benefits**

Less clear are subsections (3) and (4) of section 626.1. These sections purport to describe or define those payments received by a claimant from what shall be referred to as “other” sources “. . . as a result or otherwise in respect of the accident” and that relate to a particular head of damages.

These subsections indicate that an award must be reduced by the aggregate of all payments from these “other” sources. Eight forms of “other” source payments are set out in subsection 4. Briefly described they are:

- a) no fault benefits received by a non-Alberta resident pursuant to their auto insurance policy (or non-resident Section B benefits);
- b) medical, sickness, and accident benefits not provided under the *Alberta Health Care Insurance Act*, (or the equivalent legislation for a non-resident)
- c) proceeds under Part 5 of the *Insurance Act*, subpart 6 (or the equivalent out of province legislation)
- d) Income continuation or replacement benefits (pursuant to a private disability policy)
- e) Benefits under an income replacement plan referred to in s.15.1
- f) CPP disability pensions (or equivalent legislation for non-Canadians)
- g) Out of province benefits paid under legislation equivalent to the *Workers Compensation Act*
- h) Any other payments, benefits or compensation received pursuant to the laws of any jurisdiction other than those referred to above in (e), (f), (g).

Subsection (7) deals with the issue of premiums. Previously the Supreme Court of Canada in cases such as *Cunningham v. Wheeler*, [1994] 1 S.C.R. 35 had dealt with the area of double recovery, by indicating that payments or benefits received pursuant to a policy of insurance for which the claimant had paid premiums were not deductible from a damage award.

In order to deal with the issue of premiums, since those payments are clearly deductible now under this new section, the legislators have added subsection (7). That indicates that the court can take into account premiums or other amounts paid by the claimant in respect of the “other” source payments. The courts will likely add back into the claimant’s award the expense of obtaining the plan or coverage, either in whole or in part. There is no guidance offered by the subsection in that respect, and the first written decision from the bench dealing with this issue will be much awaited, to be sure.

### **c. Elimination of Subrogation**

Finally, subsection (6) deals with the issue of subrogation. Reference to subsection (3) suggests that the limitation created in subsection (6) as to subrogation relates to the sources (government or insurers) identified in subsection (4). In other words, those parties or insurers making payments falling under subsection (4) would not be able to subrogate. This results in an interesting conflict between many contracts (between claimants and their long term disability insurers, for example) and the *Insurance Act*.

Subsection (5) further muddies the waters to some degree. It provides that the legal obligation to make payments referred to in subsection (3) [and by default, subsection (4)] must be established or acknowledged “before the award”. It is assumed that the intent of this section was to define the parameters of payment. An acknowledgement or establishment of the legal obligation must be made before the deduction to the award can be made. The intention of this section is presumably to ensure that the claimant is actually going to receive those payments before the insurer is entitled to deduct them from the award.

Some thoughts on subsection (5) are that the words “payment being established or acknowledged before the award” reflect the concept of arbitration or some other mechanism nailing down the legal obligation to make the payment, before the court decision in the tort-related claim. Similarly an acknowledgement of obligation to make payment would have to occur before the court decision in the tort action. One could see a situation where a claimant was denied or cut off of Section B benefits as a result of a

motor vehicle accident-related injury. He or she sues his or her own insurer for no fault benefits, and commences another action against the tortfeasor. Arguably because of subsection (5), the decision of the court would have to be given in the Section B action, before the insurer for the tortfeasor could deduct any Section B benefits from the claimant's award.

Certainly the changes mandated by section 626.1 are significant to the way MVA related claims are dealt with, and awards relating to accidents occurring on or after January 26, 2004 will reflect that. Consideration of the areas of net of tax, deduction of benefits from "other sources", and subrogation are now addressed in legislation. Arguably, the words "double recovery" may be a thing of the past. Undoubtedly, section 626.1 will require and result in definition and interpretation by the Alberta Courts.

## **2. Amendments in force October 1, 2004**

The majority of the reforms to come into force on October 1, 2004 are instituted by regulation. Probably most controversial of the reforms is the \$4000 limit to recovery for pain and suffering for minor injuries. The definition of the term "minor injury" and how the nature of an injury is to be determined is set out in various Regulations rather than the *Insurance Act* itself.

### **a. Minor Injury Regulation (A.R. 123/2004)**

The term "minor injury" is defined in section 1(h) of the Minor Injury Regulation as follows:

- (i) a sprain,
  - (ii) a strain, or
  - (iii) a WAD injury
- caused by that accident that does not result in serious impairment.

"Serious impairment" (s. 1(j)) means 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 or the essential tasks of the claimant's training or

education, or the normal activities of the claimant's daily living that has been ongoing since the accident and that is expected not to improve substantially. Sprain, strain and WAD injury are also defined (ss. 1(k), (l), and (n)) with a WAD injury being a whiplash that does not include neurological signs nor a fracture nor dislocation of the spine.

The scheme also sets out various Diagnostic Protocols for the determination of what a minor injury is under the Diagnostic and Treatment Protocols Regulation. If a claimant is not diagnosed and treated in accordance with the Diagnostic and Treatment Protocols Regulation, the injury shall be considered to be a minor injury unless the claimant can establish that the injury would have resulted in serious impairment even if the treatment protocols were followed (s. 5). The total amount recoverable as damages for non-pecuniary loss for all minor injuries sustained by a claimant as a result of an accident shall not exceed \$4,000 (s. 6).

The definition of minor injury could be extremely far-reaching. One will only be able to recover more than the \$4000 cap for a whiplash, for example, if one is left with a substantial inability to perform one's job, schooling or activities of daily living. The Courts will undoubtedly be asked to determine what "substantial inability" is.

The Regulation also sets out criteria for when a claimant suffers more than one injury (s. 7). If a claimant sustains one or more minor injuries and one or more non-minor injuries as the result of one accident, if the non-minor injury alone would result in award for non-pecuniary loss of less than \$4,000, the total amount recoverable for all injuries shall not exceed \$4,000.00. If, however, the non-minor injury alone would result in award for non-pecuniary loss of more than \$4,000, the total amount recoverable for non-pecuniary loss for all injuries shall be the total the amount of damages assessed for the non-minor injury and the amount of damages assessed for non-pecuniary loss for the minor injury. In other words, if one suffers both a minor injury and a non-minor injury, if the non-minor injury would attract less than \$4000, the limit of recovery remains \$4000. If however the non-minor injury would attract damages of more than \$4000, the claimant

can recover up to \$4000 for the minor injury plus whatever figure is appropriate for the non-minor injury.

The Regulation only applies to injuries arising out of motor vehicle accidents. Therefore, if one suffers a strain or sprain from a slip and fall, for example, one will not be limited to \$4000 in damages for pain and suffering.

If either the claimant or insurer disagrees as to whether an injury sustained by a claimant is a minor injury, either party may give notice to the other indicating that they desire to have a Certified Examiner assess the claimant (s. 8). That notice must also specify the name of the proposed Certified Examiner. The receiver of the notice must then either accept that Certified Examiner or provide notice that they do not accept that Certified Examiner and provide the name of their chosen Certified Examiner. If the parties still cannot agree on a Certified Examiner, either party may apply to the Superintendent of Insurance to select a Certified Examiner. The Superintendent then has five business days to choose a Certified Examiner, but the Superintendent may not choose an Examiner who was proposed by either party. The scheme of requesting a Certified Examiner cannot take place until at least 90 days have passed since the accident and only one assessment of the claimant in respect of the accident may be carried out. A Certified Examiner cannot be someone who has already diagnosed or treated the claimant, or been consulted with respect to the diagnosis or treatment of the claimant in respect of any injury arising from the accident.

The Certified Examiner must make reasonable efforts to schedule the assessment within 30 days of the referral (s. 9). When the examination by the Certified Examiner takes place, the Examiner must assess the claimant in order to determine whether the injury is a sprain, strain or WAD injury which results in serious impairment (s. 10). The Certified Examiner is allowed to request the claimant to authorize release of all treatment information and if the claimant without reasonable excuse fails to attend an assessment, or refuses to answer any relevant questions of the Certified Examiner, the claimant's injury shall be considered to be a minor injury.

Within 30 days of the examination, the Certified Examiner must prepare an opinion in the prescribed form as to whether the injury is minor or not and a copy of that opinion must be provided to each party (s 11). The cost of the assessment by a Certified Examiner is at the expense of the party requesting the assessment (s. 13).

Essentially, the Certified Examination will allow an insurer to obtain an IME of a claimant outside the Rules of Court. The Examination can take place before litigation is commenced but only one such Examination can occur. The insurer however will not be able to easily choose who it wants to do the Examination as the claimant can disagree with the insurer's choice in which case the Superintendent will choose the Examiner.

The Regulation indicates that the Superintendent of Insurance must establish a Registrar of Certified Examiners. The eligibility requirements for a Certified Examiner's position are also set out under the Regulation (s. 16). A physician is a Certified Examiner if the Council of the College of Physicians and Surgeons of Alberta indicates that he or she has met various requirements. Those requirements are that the physician must be an active practicing member under the *Medical Profession Act*, have successfully completed an examination approved by the Council for admission as a Certified Examiner and have demonstrated to the satisfaction of the Council that the physician has the appropriate knowledge base.

Since the Regulation comes into force on October 1, 2004, it does contain some transitional provisions (s. 18). A physician may be a Certified Examiner under the Regulation even without meeting the above requirements for two years from the date the Regulation comes into force if the College of Physicians and Surgeons notifies the Superintendent that the physician is an active member under the *Medical Profession Act* and is in the opinion of the Council, able to perform the functions of a Certified Examiner. Therefore, it is expected that for the first two years of the Regulation, all active members of the College of Physicians and Surgeons in Alberta will be Certified Examiners, but if they wish to maintain that status, they will have to meet the more

stringent requirements including the passing of an exam. The Regulation expires on September 30, 2011 (s. 19).

Time will tell how many physicians are actually interested in becoming Certified Examiners once the transitional provisions expire. It is speculated that many physicians will not be keen to write an exam to become a Certified Examiner. The requirement of producing a report within 30 days will also be very difficult for many busy physicians to meet.

#### **b. Diagnostic and Treatment Protocols Regulation (A.R. 122/2004)**

The Diagnostic and Treatment Protocols Regulation sets out how various health care practitioners including physicians, chiropractors and physiotherapists are to treat those involved in motor vehicle accidents. This paper will not delve into the minutia of detail contained within this Regulation, but the Regulation does specify how a diagnosis of a strain, sprain and whiplash-associated disorder is to be made and how each of these injuries is to be treated. The Regulation also specifies how many chiropractic and physiotherapy visits may be authorized dependant upon whether a sprain, strain, or whiplash-associated disorder is diagnosed (ss. 7-21). For example, if a 1<sup>st</sup> or 2<sup>nd</sup> degree strain is diagnosed, a health care practitioner may authorize no more than a combined total of 10 medical, physical therapy, chiropractic and adjunct therapy visits.

Clearly one of the goals of the Regulation is prompt treatment. Section 22(2) indicates that authorization for treatment under the Protocol must be issued within 90 days of the accident.

Sections 24 to 29 of this Regulation set out a new type of health care practitioner called an Injury Management Consultant. An Injury Management Consultant may be used if an injury has not resolved or is not resolving within 90 days from the date of the accident. The Injury Management Consultant may then provide advice and report about the diagnosis or treatment or recommend a further assessment. Essentially this provision allows the health care practitioner to obtain a second opinion. The Superintendent of

Insurance is to establish and maintain a Registrar of Injury Management Consultants. A health care practitioner is an Injury Management Consultant if he or she is an active physician, chiropractor, or physiotherapist and has demonstrated a certain knowledge base to the College of Physicians and Surgeons. Similar to the transitional provision for a Certified Examiner, all physicians, chiropractors and physiotherapists are automatically Injury Management Consultants for the first two years of the Regulation so long as they are actively practicing.

When reading the Minor Injury Regulation and the Diagnostic and Treatment Protocols Regulation together, it becomes evident that the determination as to whether an injury is minor or non-minor must be based on an assessment in accordance with the diagnostic protocols established under the Diagnostic and Treatment Protocols Regulation. Therefore, although the Diagnostic and Treatment Protocols Regulation seems to suggest that a claimant may choose whether he or she wishes to be assessed under that Regulation, if a claimant wants to receive compensation for a sprain, strain or whiplash, the claimant must agree to be assessed in accordance with the protocols under the Diagnostic and Treatment Protocols Regulation. This appears to be the case whether the injury is found to be minor or non-minor.

This Regulation also addresses Section B Accident Benefits (Part 4). It indicates that an insured or health care practitioner who wishes to make a claim under Section B must send the insurer a completed prescribed form within ten business days of the date of the accident or as soon as practicable thereafter. An insurer must then within five business days of receipt of the prescribed claim form, decide whether the Section B claim will be denied or not. An insurer is then obligated to pay any claims that are authorized under this Regulation. In other words, the insurer is only obligated to pay the number of treatments that the Regulation requires, dependent upon what diagnosis is made of the injury.

Although the medical profession was consulted in the drafting of this Regulation, the writer questions how pleased doctors will be to be told that they may only authorize a

certain number of visits with therapists and that even visits with general practitioners are limited. The doctors and therapists are now being told how to treat and diagnose patients. One would not be surprised to see some doctors turn patients away once the doctor finds out that the patient was injured in a motor vehicle accident.

**c. Automobile Accident Insurance Benefits Amendment Regulation (A.R. 121/2004)**

The Automobile Accident Insurance Benefits Amendment Regulation also comes into force on October 1, 2004. It increases the limit for medical expenses to \$50,000 per person from the current \$10,000 per person. It also includes a number of sub-limits including \$750 for chiropractic services, \$250 for massage therapy and \$250 for acupuncture (s. 5). In order to claim expenses under Section B, one must comply with the diagnostic and treatment criteria set out in the *Diagnostic and Treatment Protocols Regulation*. This will undoubtedly require insurers to carefully monitor their insureds who make Section B claims to ensure that they do not attend for more treatment than the Regulation allows.

The insurer is liable to pay treatment costs even when the claimant has another insurance plan if the injury is one to which the *Diagnostic and Treatment Protocols Regulation* applies. Therefore, Section B insurers will have to pay treatment expenses for sprains, strains and whiplash injuries even when the claimant has a private insurance plan that would cover such expenses.

Section B maintains the same limits for death benefits, but now includes benefits for “adult inter-dependent partners” as defined in the *Adult Inter-Dependent Relationships Act*, S.A. 2002, c. A-4.5. Section B now includes a limit of \$400 per family for grief counseling (s. 6).

With respect to disability payments, the new Regulation defines average gross weekly earnings to be the greater of the average gross weekly earnings for the claimant’s occupation for the four weeks preceding the accident and the average gross weekly

earnings for the occupation of the claimant for the 52 weeks preceding the accident. However, one is still only entitled to a maximum of \$300 per week (s 6).

The new Regulation now indicates that the insurer must pay the expense incurred by the insured in completion of the medical report portion of the required Section B Medical Proof of Claim Form (s. 8).

The new Regulation also dramatically restricts the insurer's ability to obtain an IME (s. 8(g)). The insurer has no right to an IME with respect to strains, sprains or whiplash injuries with respect to any treatment, test or assessment authorized under the *Diagnostic and Treatment Protocols* Regulation. With respect to any other injuries, the insurer has no right to an IME for which chiropractic, massage therapy or acupuncture services are provided and no right to an IME for psychological services up to \$600, physical therapy up to \$600 and occupational therapy up to \$600 per person.

The Regulation provides that insurers must pay disability benefits within 30 days of the claim being submitted and must pay all treatment expenses within 60 days after the completed prescribed claim form is received.

#### **d. Automobile Insurance Premiums Regulation (A.R. 124/2004)**

The Automobile Insurance Premiums Regulation also comes into force October 1, 2004. It sets out a detailed formula for the calculation of premiums and even a potential refund of premiums if the premium that an insured is paying as of October 1, 2004 is more than is allowed under the new grid (s. 2). The Regulation indicates that no insurer may charge or collect a premium of more than the grid premium (s. 3). The Regulation also sets out a complaint and arbitration procedure (ss. 13-16).

The Regulation specifies that the base premium for \$1,000,000 in liability coverage in Edmonton shall be \$1,980.00, in Calgary shall be \$1,800.00 and in the rest of the Alberta shall be \$1,440.00. This is the base premium which can be increased or decreased dependant upon driving and claim histories. The Regulation specifies that the difference

between the Edmonton and Calgary base premium must be eliminated by October of 2007. It should be noted that the grid applies to premiums for liability coverage only and has no impact on what insurers charge for Section C (collision) coverage.

The Plaintiffs' Bar in Alberta has vowed to challenge the new Reforms. While the Regulations define many terms, it is still anticipated that those definitions will be the subject of legal interpretation and challenge. At least in the short term, litigation is expected and as a result, these new Regulations will likely be amended either by the Legislature directly or by interpretations made by the Alberta Courts. It remains to be seen whether significant reductions in insurance premiums will be forthcoming.