

***RECENT CHANGES TO NOVA SCOTIA'S AUTO INSURANCE LAWS: A PRACTICAL
LEGAL ANALYSIS***

by

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INTRODUCTION

The Progressive Conservative government in Nova Scotia found itself in a serious bind in the ramp-up to the 2003 general election. The auto insurance companies had dramatically raised their premium rates and the voters were up in arms. The Tories here saw how the voters in New Brunswick had just reduced the commanding majority of Bernard Lord's Tory government to a corporal's guard over this very issue and the government of Premier John Hamm was determined to avoid that fate.

First, the government announced a freeze on premiums. Then the Tories campaigned on a 20% across-the-board rollback.

Evidently, the voters in Nova Scotia were not terribly impressed. They slashed the Hamm government from a majority to a minority. The NDP, who had campaigned in favour of a public auto insurance option, increased their representation in the Legislature and were once again the Official Opposition.

Shortly after the election, the government hastily called the Legislature into session. They introduced, as Bill 1, the grandly styled "***Automobile Insurance Reform Act***"¹. The main purpose of that legislation, we were told, was to enable the government to implement the promised 20% rollback. As a sop to the hurt feelings of the auto insurance industry, the Bill would include measures to cap claims for "minor injuries" which, according to the insurance companies, were getting completely out of hand.

Because they are a minority government, the Tories needed the votes of the third party in the Legislature, the Liberals, in order to pass the Bill. The Liberals wisely insisted that the government show the House not only the *statute* they were proposing but also the important *regulations*, which are traditionally made in secret by Cabinet and which contain many crucial details about how a statute will work in practice. So the Tories produced a set of regulations for everybody to see. There was some minor tinkering between the Tories and Liberals over the wording and, in October 2003, the Tory bill passed with the help of the Liberals.

Then the insurance companies went ballistic. They complained bitterly about the regulations. So the Government promptly withdrew the regulations they had used to get the support of the Liberals. The Premier responded publicly to the insurance lobby's concerns by promising to do a better job with the regulations on his next try. Indeed, Premier Hamm was apparently so worried about criticism from the insurance lobby that he promised *in public* that the insurance companies would be quite happy with the next set of regulations. It seems that Premier Hamm was true to his word.

This paper attempts to analyze those important and incredibly far-reaching changes to the law in concrete and practical terms.

¹ S.N.S. 2003 c.1. All references *infra* are to the ***Insurance Act***, as amended

THE ‘DEAL’

The deal behind the changes to the *Insurance Act* and of the related regulations² promulgated by the Tory Cabinet in November 2003 was simple enough: in exchange for a one-time 20% reduction in car insurance rates, the government would limit forever the amount that insurance companies would have to pay out in claims for minor injuries that healed quickly.

To many Nova Scotians that seemed fair enough. The impression created by the insurance lobby group, the Insurance Bureau of Canada, was that insurance companies were being driven to the brink of bankruptcy by inflated demands of those who claim to have suffered minor (or “soft tissue”) injuries and that, in particular, was why they have raised their premiums so drastically over the last year. The insurance industry had long maintained (with some success in the minds of the public and the Courts of Nova Scotia) that most, if not all, of these “soft tissue” claims were phoney.

It was only in relatively recent times that our Nova Scotian courts slowly began to recognize the overwhelming medical and scientific evidence that shows that injuries to the muscles, cartilage and nerve tissues of the neck and spine that often result from motor vehicle accidents (so-called “soft tissue” or “whiplash” injuries) are physically real, medically provable and frequently seriously debilitating. Judgments for damages in these cases slowly improved in Nova Scotia and, only in the last few years, they began to approximate the damages assessed in similar cases by the courts in other jurisdictions in Canada. Suddenly, according to the insurance companies, it was no longer profitable to be in the auto insurance business in Nova Scotia. They remain here, it seems, only out of the goodness of their corporate hearts.

Contrary to the impression one might have from watching American television or from listening to the Insurance Bureau, people injured in car accidents in Nova Scotia were never over-compensated. There never were any multi-million dollar damage judgments for “pain and suffering” in this province, nor have there been any such judgments here for soft tissue injuries in the six-figures. That is because, way back in 1978, the Supreme Court of Canada capped general damages for pain and suffering – everywhere in Canada – at a maximum of \$100,000.³ Just to be clear: that maximum is reserved for the *very worst possible* cases, for example, those as severe as quadriplegia or life-long coma. Most cases, of course, are not so severe and the judgments for damages are not as high as that. The Nova Scotia Court of Appeal declared, in 1992, that the range of general damages in cases of “persistently troubling but not totally disabling injury” (i.e. many of the so-called “minor injuries”) is “from \$18,000 to \$40,000”.⁴

The insurance companies in Canada and Nova Scotia have, of course, been the beneficiaries of these judicially imposed limitations on damages for pain and suffering. Nonetheless, the

²*Automobile Insurance Tort Recovery Limitation Regulations*, N.S. Reg. 182/2003 as am. by N.S. Reg. 196/2

³ *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229; *Teno v. Arnold*, [1978] 2 S.C.R. 287 and *Thornton v. Prince George Board of Trustees*, [1978] 2 S.C.R. 267. This would equate to about \$250,000 when adjusted for inflation.

⁴ *Smith v. Stubbart* (1992), 117 N.S.R. (2d) 118. Approximately \$21,000-48,000, adjusted for inflation.

insurance industry in Nova Scotia has always vigorously resisted all soft tissue and “minor injury” claims through the use of aggressive and costly claims-handling tactics. These tactics include routinely refusing to discuss settlement until the injured person has produced her family doctor’s entire medical file for the insurance company to read (not just pertaining to the injury at hand, but so they can read about each and every time she has sought medical treatment for *anything, ever*), routinely subjecting the injured person to questioning under oath by their lawyers before a Court Reporter about intimate details of her private life and medical history, even in cases where there is no serious dispute on the facts of the case and all the relevant information is already known, and routinely instructing their lawyers to file documents in the public court registries saying that she was drunk or on drugs at the time of the accident, when there is absolutely no evidence to support such an allegation and even when the insurance company itself does not actually believe that to be true. These costly tactics are used by insurance companies deliberately to humiliate claimants and to cause them to accept lower settlements than they would achieve by going to court. And, sadly, these tactics often work. The point is that, when insurance companies talk about the amounts they pay out in “minor injury” cases, those amounts *include* the enormous expenses and huge legal fees they incur as a result of their own aggressive settlement strategies.

The Insurance Bureau, for its part, never endorsed the Government’s 20% rollback. Their public position was one of continued outrage at the rate cuts.

No matter what you might think of the merits of that deal between the Tory/Liberal alliance and the insurance lobby, the fact is that the changes they actually have made to the law go far beyond what they ever talked about in public. This scheme does not, in fact, limit only insurance claims for minor injuries to \$2500. These changes are in reality much broader and more far-reaching than that. And the wording used to put this scheme into the law is devious, intentionally convoluted and, I believe, deliberately misleading.

SCOPE OF THE CHANGES

The Government and the insurance industry have portrayed these amendments as minor tinkering with the way insurance claims are paid. The impression they are trying to convey is that these amendments to the law only affect the insurance companies and those few malingerers out there who are making inflated claims for soft tissue injuries. That is quite untrue. In fact, these changes affect the legal rights of every single motorist in Nova Scotia, those of every single passenger in every single car and those of each and every pedestrian in this Province who, through no fault of their own, is injured by someone else’s negligent driving.

According to the *Act*, these changes apply to every “action for loss or damage from bodily injury or death arising directly or indirectly from the use or operation of an automobile” [see s. 113A] and they apply “notwithstanding any enactment or rule of law” [see ss. 113B (2), (4)].

These changes, as you will see, will also have profound consequences for every single *employer* in Nova Scotia every time an employee is injured in a motor vehicle accident.

In other words, in order to make these changes to please the insurance industry the Government found it necessary to change the laws as they affect all of us. This may be useful to keep in mind as we proceed with this analysis.

BURDEN OF PROOF

When it comes to determining whether an injury is or is not a “minor injury” this scheme puts the burden on the *injured person* to prove that it “is not a minor injury”: Reg. 5 [emphasis added].

Normally in a lawsuit, the burden of proof falls on the party that wants to assert something as a fact (“I was acting in self-defence.” or “This is a minor injury.”) That is because it is only fair to make the party that wants to rely on a particular fact prove that fact. It is also because legal procedure has long recognized the logical impossibility of proving a *negative*. By reversing the onus and putting it on the injured person to prove the negative this scheme declares, for all practical purposes, that ***all injuries are minor injuries unless and until the contrary is proven.***

Now wait until you hear *how* someone has to go about proving that theirs is “not a minor injury”.

THE THRESHOLD QUESTION: IS IT A PERSONAL INJURY?

Let’s say you were injured in a car accident in Nova Scotia sometime after November 1, 2003. You have been laid up since getting home from the hospital and you feel terrible. Your doctor (a general practitioner) has told you that it’s too early to know when you will be better or whether or not you will be left with a continuing disability or how severe it might be. An insurance adjuster, working for the insurance company of the driver who was at fault in your accident, has come to you within a few days of the accident and has offered you a cheque for \$2500, telling you that you can hire all the lawyers you want and fight it all you want but that’s all you’ll ever get under the new legislation because you’ve only had a “minor injury”. You will, of course have to sign a Final Release in exchange for the \$2500 that will bar you from making any future personal injury claims arising from that accident.

You (and your family) need to know whether you should take the money.

The *Act* now defines “minor injury” as follows, in s. 133B:

(a) "minor injury" means a personal injury that

(i) does not result in a permanent serious disfigurement,

(ii) does not result in a permanent serious impairment of an important bodily function caused by a continuing injury which is physical in nature, and

(iii) resolves within twelve months following the accident;

[emphasis added]

On the surface, that might seem straightforward. Until you see the fine print. And, as you will see, there is lots and lots of fine print. Indeed, in order to understand these amendments at all, it is important to appreciate how incredibly convoluted they really are. Of course, as any lawyer knows, the insurance industry is founded on the use of ordinary sounding language with unusual meanings, peculiar to the law of insurance. As we go through this maze you may feel like a shell-game dupe at a sideshow. That would be normal. Welcome to insurance law.

First, we have to determine, believe it or not, whether the particular injury we are talking about is a “personal injury”. Oddly, the drafters of the regulations felt it necessary to define the term “personal injury” as it is used in that section of the *Act*. More oddly still, they purport to define it by telling us *some of what it does not mean* rather than what *it means*, in Reg. 2(1) (d), as follows:

"personal injury" does not include

(i) a coma resulting in a continuing serious impairment of an important bodily function,

(ii) chronic pain that

(A) is diagnosed and established as chronic pain by a medical specialist appropriately trained in the diagnosis and management of pain disorders,

(B) is a direct result of a physical injury sustained in the motor vehicle accident with respect to which the claim is brought,

(C) results in a continuous serious-impairment of an important bodily function, and

(D) is moderately severe or severe pain, as classified in the American Medical Association *Guides to the Evaluation of Permanent Impairment*, 5th edition,

(iii) a burn resulting in serious disfigurement,

(iv) an amputation of a major limb;

[emphasis added]

So it's clear that a minor injury is *not* one involving a serious coma (but it may be an unserious one, whatever that might be), chronic pain (as strictly defined), a seriously disfiguring burn or the amputation of a "major" limb. The corollary, of course, is that *anything else* might be found to be minor.

So it's back to the definition of "minor injury".

WHAT IS A "MINOR INJURY"?

Throughout this scheme, as we've already seen, things are often defined *in the negative*. This is highly unusual in legislative drafting. Drafters are trained that matters stated in a positive form are clearer and easier to understand than those that are framed as negatives or exceptions. For this reason, definitions in statutes and in regulations are almost invariably stated in a positive form. That is, we are usually told what things *mean*, not what they *don't mean*. This preference for clarity would hold, of course, only to the extent that the drafters are committed to making the legislation easy to understand. If the drafters wished to obscure their intentions there is no better way to do so than to define a phrase by saying what it *does not* mean.

Another great way to add obscurity to legislation is to create definitions within definitions: define something then define the terms of that definition, then define the terms that define those terms. That is what we have here.

As the direct result of a political bargain in the Legislature (between the Liberals and the Tories) we ended up with a definition of "minor injury" that combines a couple of negatives with a positive. The positive ("resolves") is further defined in three or four more definitions. No wonder even experienced personal injury lawyers are having a hard time following this. I frankly doubt that anyone is truly expected to follow it. But let's press on.

From that definition we glean that a "minor injury" is one that *does not* result in a "permanent serious disfigurement", and that *does not* result "in a permanent serious impairment of an important bodily function, etc." but which *does resolve* within 12 months.

Permanent Serious Disfigurement

We first have to determine whether or not the injury will result in "a permanent serious disfigurement". Obviously, that disfigurement cannot be the result of a burn, because if it is the result of a burn it is not a "personal injury" and hence it cannot be a "minor injury". Other non-burn disfigurements qualify for the exception to the "minor injury" presumption only if they are deemed to be "serious". Whether any given non-burn disfigurement is "serious" is, of course, very much a matter of personal opinion.

Permanent Serious Impairment

Next there is the question of whether the injury will “result in a permanent serious impairment of an important bodily function caused by a continuing injury which is physical in nature” [emphasis added].

Not content to leave it to our imaginations (or, Heaven forbid, to a judge to decide), the drafters have come to our aid with a handy definition of “serious impairment” [s.113B(1)(b)], as follows:

(b) "serious impairment" means an impairment that causes substantial interference with a person's ability to perform their usual daily activities or their regular employment.

Now hold that thought. The drafters of the regulations have given us, not one, not two but *three more definitions* so that we can apply them to the definition of “serious impairment, so that we can apply all of that to interpret the meaning of “minor injury” in the amended *Insurance Act*. So we now have to consider the definitions of “regular employment”, “substantial interference” and “usual daily activities”, ostensibly because we (or a judge) may not know what these words mean in English, but in reality they are defined so they achieve the highly restricted meanings the insurance companies want them to have. These definitions are found in Reg. 2 (1)(e)(g) and (h):

(e) "regular employment" means the essential elements of the activities required by the person's pre-accident employment

(g) "substantial interference" means, with respect to a person's ability to perform their regular employment, that the person is unable to perform, after reasonable accommodation by the person or the person's employer for the personal injury and reasonable efforts by the injured person to adjust to the accommodation, the essential elements of the activities required by the person's pre-accident employment;

(h) "usual daily activities" means the essential elements of the activities that are necessary for the person's provision of their own care and are important to people who are similarly situated considering, among other things, the injured person's age.

[emphasis added]

Accordingly, if you can be said to be able *either* to perform the “essential elements” of your job (even if you can’t really do the job) *or* if you can be said to be able to look after the “essential elements” of your “*own care*” (whatever that is), but *not* that, say, of your children or your family, then you *do not* have a “serious impairment”.

Note that the definition of “substantial interference” requires in part that the injured person benefit from circumstances completely outside of her control, in that she must prove that *her employer* has failed to make “reasonable accommodation” for her disability. Hence, if *her employer* did not act “reasonably” in accommodating her return to work *she* will not be able to establish that her injury is not a “minor injury”.

And please note that the injury in question must always be “physical in nature”. That means that diagnosed psychological conditions resulting from an accident, no matter how severe will *only ever* amount to “minor injuries”. The typical emotional consequences of traumatic physical injuries are all well known in medical science. They include anxiety, clinical depression, sleep disturbance, fear of driving, sexual dysfunction, and post-traumatic stress disorder. Moreover, it is an open question whether the sometimes drastic personality disorders that can result from “closed head injuries” are primarily physical or primarily psychological in nature. The insurance companies have long resisted all claims made for psychological injuries, including those arising from “closed head injuries”. In the same way that they denied for years and years that soft tissue injuries even existed because they do not show up on an X-ray, the typical insurance company response to *diagnosed* cases of psychological injuries has long been to say, in effect, that “it’s all in her head”, i.e. it is either being imagined by the claimant or it is being faked. The point here is that the symptoms of the psychological injuries received in an accident are often more severe and outlast the symptoms of the purely physical injuries. Yet ***all psychological injuries*** are now, once and for all, deemed to be “minor injuries”. The maximum payment for a “minor injury” is \$2500. This is a huge, undeserved victory for the insurance industry.

The attitude of the insurance companies – and now apparently of the Government of Nova Scotia – towards the proven psychological consequences of traumatic injury reminds me of the way that young soldiers fighting in the trenches of World War I, suffering from what we now understand to be post-traumatic stress disorder, were routinely lined up by their commanders and shot for “cowardice”. The difference, of course, is that the World War I commanders did not have the benefit of modern medical science. The insurance companies – and the Tory government – have no such excuse.

And so what does all this mumbo-jumbo mean to this point? It simply means that these regulations are designed to ensure that anyone who dares to try to prove that they have a “serious impairment” and, hence, an injury that is not a “minor injury” will face a long, hard uphill battle.

Resolves within 12 Months

But we're not finished yet. We're not even close. You still don't know if you have a "minor injury" until you know whether the injury is one that "resolves within twelve months following the accident".

Again, on the surface that doesn't seem so difficult. After all, we all know what "resolves" means, right? It means it gets better, that the injury has healed. The pain goes away and you're pretty much back to normal, right? I am afraid not.

Once again, those helpful drafters of the regulations decided to give us a hand with the following definition of the English word "resolves". It is found in Reg. 2(1) (f)(i) and (ii):

(f) "resolves" means

(i) does not cause or ceases to cause a serious impairment of an important bodily function which results from a continuing injury of a physical nature to produce substantial interference with the person's ability to perform their usual daily activities or their regular employment, or

(ii) causes a serious impairment which results from a continuing injury of a physical nature to produce substantial interference with a person's ability to perform their usual daily activities or their regular employment where the person has not sought and complied with all reasonable treatment recommendations of a medical practitioner trained and experienced in the assessment and treatment of the personal injury.

Remember those restrictive definitions within definitions we just looked at for "serious impairment", "regular employment", "substantial interference", and "usual daily activities"? Good, because we'll need them all again to figure out what the word "resolves" means according to this new law because they're all used again in the definition of "resolves".

So let's try to break this all down in practical terms.

Let's start with the premise that an injury is a "minor injury" if it resolves within 12 months. You will notice that the definition of "resolves" has little to do with the healing process. Rather, the focus is on the injured person's ability to perform the "essential elements" of their pre-accident employment and on the person's ability to provide for her "own care".

Employment

According to this definition, an injury resolves if the injured person is able to perform the “essential elements” of her pre-accident employment, after reasonable accommodation by the person’s employer and after reasonable efforts by the injured person to adjust to the accommodation.

Put another way, if an injured person is able to perform the “essential elements” of her pre-accident employment within 12 months of the injury then the injury has “resolved”.

Of course, just what the “essential” (versus ‘non-essential’) elements of any job are is very much a matter of opinion and, hence, readily open to dispute. As a practical matter, the insurance companies will decide what it means on a case-by-case basis. (Oh, and if you disagree, you can always take them to court.)

Accordingly, if an injured person is unable to perform the “essential elements” of her pre-accident employment (whatever those may be) but their employer is able to “accommodate” their injury somehow (by modifying employment duties or equipment or whatever) thereby enabling the injured person to resume employment, even on some limited or modified basis, then the injury has “resolved” under this definition.

Or, as mentioned, if the employer *unreasonably* says that it is unable to accommodate the injured employee, the employee’s injury is deemed to have been “resolved” under this cruel definition.

(Imagine, for a moment, the absurd position that this puts any employer in.)

So, regardless of whether the injury has gotten any better, if, within 12 months, an injured person can perform the ‘essential elements’ of their pre-accident employment or if their employer has reasonably accommodated the injured person and modified the job and/or duties to take into account any disability that the person may have as a result of the injury thereby enabling the injured person to resume some employment, then the injury has “resolved”.

Usual Daily Activities

An injury *also* is considered to be “resolved” if, within 12 months of the date of the injury, the injured person is able to perform her ‘usual daily activities’.

The term “usual daily activities” means only the “essential elements” required for one’s “own care”. Again, what these “essential elements” are exactly is largely a matter of opinion. The definition –deliberately, I presume – does not tell us what these “essential elements” are supposed to be. Of course, that leaves it to the *insurance company* to tell *you* what it means.

So, regardless of whether an injured person can return to work under any employment conditions, if within 12 months of the date of the injury the injured person is able to care for

herself then the injury has “resolved” for legal purposes and the injury is, by this definition, a “minor” one.

Clearly, given the wording of this ridiculous scheme, most injuries will fall within this encompassing definition of ‘minor injury’.

Over all, the purpose of the definition is obviously to distort the ordinary meaning of the word “resolves” so that the insurance companies can say that the injuries of a person who is still experiencing real pain and disability have “resolved”, i.e. healed, when they have not. This is being done so that the insurance companies can say that those claims arise from “minor injuries” when they do not. And this is being done so that the insurance companies can force people to accept a *maximum* payment of \$2500, when we were told that that limit would only apply to what are supposedly frivolous “soft tissue” claims.

Looking at the strange way this definition is worded, two things are readily apparent. The first is that the word “resolves” bears little resemblance to the word most people who speak English would understand. It certainly does not mean “gets better”. The second thing you notice when you take the time to ponder it is that you can be quite sick and remain very disabled from your injury for a very long time and yet, under these rules, your injury would be considered to have been “resolved” and hence it would be a “minor injury”.

Obviously this was deliberate. This was not simply a drafting error. Far from being a law that provides limited relief to people with minor injuries in car accidents, as it was publicly proclaimed by the Government, this law allows the insurance companies to classify pretty much any injury they want as a “minor injury” and puts the injured person in the invidious position of having to prove – in the face of a morass of convoluted regulation – that theirs is *not* a minor injury.

So, if you’ve come this far and you still think you might have a shot at proving that you *do not* have a minor injury, wait until you see the rules of proof they’ve come up with.

PROOF OF ‘NOT A MINOR INJURY’

Before you decide whether to take the \$2500 or take on a multi-billion dollar insurance company in court, you should know not only *what* you have to prove but also *how* you are *allowed* to go about trying to prove it under these new rules. I’ve already mentioned the reverse onus and the logical difficulty of proving a negative. Those obviously operate in favour of the insurance company. The drafters of this scheme, however, were not content to leave it at that.

In order to appreciate the gravity of these changes you first have to know that, generally speaking, the parties to any lawsuit are free to put whatever admissible evidence they can muster before the court in their attempt to persuade the Judge to their point of view. Judges – who are

seldom pushovers – are pretty darn strict when it comes to the nature and quality of the evidence they will accept to convince them of *anything*. Yet this scheme does not stop at reversing the onus of proof. And it is not content to rely on the judges to be able to know when something is proven or not. The regulations actually prescribe *the evidence* that the injured party must use in proving her case. This is, to put it mildly, highly unusual.

Typically, an accident victim will present expert medical evidence from her family doctor in addition to that of any of the surgeons and specialists who have assessed or treated her (normally traumatic and physical medicine specialists, orthopaedic surgeons, neurologists, etc.) as well as the evidence from any physiotherapists or occupational therapists, etc she may have seen. This would be the normal kind of evidence called by the victim in a case of on-going, or to use the medical jargon, “chronic” pain.

According to these new regulations, none of that evidence would be admissible in a chronic pain case. The *only* evidence that would be acceptable in court would be the expert evidence of “**a medical specialist appropriately trained in the diagnosis and management of pain disorders**” [Reg. 2(1)(d)(ii)(A)]. In plain words: you need a pain specialist.

What the average person may not know is that, in all of Nova Scotia, there are fewer than five pain specialists. I personally know of none outside of Halifax but there might be one in Sydney. The members of Cabinet who approved these regulations might not know that these few pain specialists are already so busy that, even before these regulations, it already took *years* on a waiting list to get in to see one of them. (That is, of course, if you are prepared to forget that that Cabinet was presided over by John Hamm, MD who may well know each one of these specialists by their first name.) But even John Hamm might not be aware that these few specialists can be and are hired and paid by insurance companies to testify for *them* in court.

To be clear: If your claim involves chronic pain you have to wait however long as it takes to see a pain specialist. You have to pay the pain doctor to give you a medical-legal report on your condition (which would cost about \$1000) because they cannot bill MSI for it. You have to do this *before* you will even know whether you have a “minor injury” or not, which will tell you whether you should take the \$2500 or not.

Moreover, the regulations require that, for the pain specialist to say that you have “chronic pain”, it must be proven that your pain is “is moderately severe or severe pain, as classified in the American Medical Association *Guides to the Evaluation of Permanent Impairment*, 5th edition”. And again that does not, in itself, appear to be unreasonable unless you happen to know that the terms “moderately severe or severe” pain are reserved for the very worst possible cases. Or unless you know that medical authorities say that a proper diagnosis cannot be made under those particularly stringent Permanent Impairment protocols until the pain has persisted for *at least two years*. And unless you know that many other medical authorities and texts categorize pain as being “chronic” after six months of continual pain. The insurance companies with their hired specialists have long argued for this highly restrictive definition in court, without success. Now

their position, right down to the edition number of the book they like, is enshrined in the law of Nova Scotia.

And of course, just because your pain specialist (if you can find one) says you have chronic pain under those prescribed Permanent Impairment protocols does not mean that the insurance company has to accept it. They are always free to hire one of their own pain doctors to examine you and give the opposite opinion. In that event you will have to call your pain specialist to come to give evidence in court at your own expense. So much for the \$2500.

From my reading of the record of the debate in the Legislature, it seems to me that the Liberals were duped into thinking that by putting the “resolves” in 12 months bit in the statute (rather than in the regulations where the Government put it) they were creating a law that says that if your symptoms persist for more than 12 months it is not a “minor injury”. If that is what they thought they were, sadly, plainly wrong.

Indeed, there is evidence in the Bill itself that the Government knew that was wrong but they let the Liberals believe it anyway (for all of Insurance Minister Ron Russell’s repeated protestations that he knew little about insurance or the Bill he was proposing because, as he said often, he is neither a lawyer nor a doctor.) That is the fact that the Bill also amended the *Limitation of Actions Act* to extend the limitation from two years to three years. The only reason for doing so that I can see is that the Government knew perfectly well that it would take *at least two years* just to get a diagnosis in a case of chronic pain from a pain specialist.

From all this it should be quite clear that no sane person would want to find themselves involved in a dispute with an insurance company under these preposterous regulations about whether or not theirs is a “minor injury”. This is, I suggest, exactly what the insurance industry set out to accomplish. They want to be able to say, “Here’s \$2500. Take it or leave it.” Whether the Government knew these things too or whether they were duped by the shell game, I cannot say.

CHANGES OUTSIDE ‘THE DEAL’

As mentioned above, ‘the deal’ proffered by the Government was that there would be a one-time 20% rollback in auto insurance premiums and in exchange the \$2500 cap on minor injuries.

Just to be clear: The \$2500 we are talking about replaces the amount that a court would give you as damages for “non-monetary loss”, which includes (but is not limited to) what we call “pain and suffering”. It does *not* cover any payment for other *monetary* losses of the accident victim, such as out of pocket expenses, lost income or lost earning capacity. The insurance companies still have to pay those aspects of the claim, whether or not your injury is deemed to be a “minor injury”.

So someone thought that this would be an excellent time to write a few more sweeteners for the insurance companies into the Province’s law books – changes that affect *all claims* by people hurt in car accidents, not just the “minor ones”. These are changes that reflect positions that

have been taken by the insurance companies before the courts for many years and which they have not be able to persuade the judges – in this province or elsewhere – that they need or deserve.

For example, s. 113A deals with another big hobbyhorse of the insurance industry that has nothing whatever to do with limiting damages in minor injury cases. It deals with *all* claims for loss of income and lost earning capacity, no matter how major or “minor” the injuries are. From now on, the insurance companies will deduct from the wage loss payments they pay you the amount of *any* payments for your lost wages, whether you actually received that money or not. This mean that wage-loss payments will be reduced by the amount of any money, for example, that you received *or that you could have received*, whether from their own auto insurer (under Section B), a group insurance policy, Employment Insurance, or even social assistance, *whether they actually got it or not*. This is a major change in the law.

Section B wage loss payments, to pick one example, are part of the mandatory so-called “no fault” accident benefits we all pay for as part of our *own* auto insurance policies. Before this change, you simply had to *apply* to your insurer for your Section B accident benefits. Section B provides for some meagre wage loss coverage on a “no fault” basis (80% of lost wages to a maximum if \$140 per week). If your Section B insurer jerked you around (which, incredible though it may seem, does happen) you could then claim the full wage loss from the negligent driver’s insurance, without having to fight *your own* auto insurer in court in a separate legal action. Now you would have to take *your own* Section B insurer to court to enforce your own policy or lose the \$140 per week “no fault” payment altogether.

Before this change, any money that you received from EI or social assistance was between yourself and the Government. Now you will have to account to the insurance company for every penny of government money that you did receive or that you *might have* received, even if you did not apply for it or receive it. Of course, this gives the insurance companies direct access to more highly personal and confidential information about every injured person. That section reads:

113A In an action for loss or damage from bodily injury or death arising directly or indirectly from the use or operation of an automobile, the damages to which a plaintiff is entitled for income loss and loss of earning capacity shall be reduced by all payments in respect of the incident that the plaintiff has received or that were available before the trial of the action for income loss or loss of earning capacity under the laws of any jurisdiction or under an income-continuation benefit plan if, under the law or the plan, the provider of the benefit retains no right of subrogation.

And s.113B (2) of the *Act* changes the law to make insurance companies liable to pay only the “net income loss, as determined by regulation”. Prior to this the insurer, on behalf of the negligent driver, was liable to pay the *gross* income loss.

Again, this is a major victory for the insurance companies. It is one they were not able to achieve fairly in court. And it is a significant change in the law made while everyone's attention was diverted by a discussion about what is, or is not, or might be a "minor injury".

Another sweetener given to the insurance industry came in the form of an increase in the "discount rate" that all court awards for personal injury are subject to and a big change in who decides how much that "discount rate" will be from now on. (The discount rate is a *deduction* made from the money you receive as damages to cover so-called "contingencies".) Prior to these changes, the discount rate was set by the Judges of the Supreme Court in the Civil Procedure Rules at 2.5%⁵. Now it is set by Cabinet and you will lose 3.5%. From now on it will be raised annually by Cabinet, based on the difference between the Government Bond Rate and the CPI. Great if you're an insurance company. Not so great if you're a Nova Scotian injured in a car accident.

That change is found in s. 113C of the *Act*:

113C In an action for loss or damage from bodily injury or death arising directly or indirectly from the use or operation of an automobile, under any enactment or rule of law, an award against the owner, operator or occupants of an automobile, any person present at the incident and any person who is or may be vicariously liable with respect to any of them, shall not be calculated using a discount rate less than the amount prescribed by the Governor in Council by regulation.

And in Reg. 4:

(1) For the purpose of Section 113C, the discount rate for calculating loss or damage from bodily injury or death is 3.5%.

(2) Effective January 1, 2005, the discount rate for each calendar year may be based on the difference between the rate set for Government of Canada bonds and the consumer price index for the previous 12 months.

Perhaps the biggest boondoggle in the entire package, however, is found in s. 113D of the *Act*, which reads:

113D Nothing in Sections 113A to 113C prevents an insurer from providing a policy or endorsement to compensate an insured with respect to damages for any award for pain or suffering or any other non-monetary loss in excess of the amount

⁵ Civil Procedure Rule 31.10 (2)

prescribed in the regulations or with respect to any other limitation on damages in those Sections.

This is the insurance companies' answer to consumers who worry that there will now be insufficient coverage available for *them* if they or a member of their family is injured in an accident caused by the negligence *another* driver. This clause permits the insurance companies to offer their customers the old pre-amendment coverage under an endorsement to *their own* auto policy (called an S.E.F 44) *for a fee*. In other words, drivers who are worried about these changes (and that should include all of us) will be able to buy the exact same coverage for themselves that they had last year for a *higher premium!*

This, of course, is exactly what the insurance industry wanted all along: to have their cake and eat it too. Quite simply, it entirely defeats the Government's 20% rollback.

CONCLUSION

From my perspective, the insurance industry manufactured a "crisis" in insurance rates in an election year as part of a co-ordinated, all-out effort to win changes in the laws that are favourable to them that they could not achieve in court or through rational public policy debate. I believe that their effort has been highly successful in Nova Scotia and I believe that this success for the insurance companies comes at the direct expense of all Nova Scotians.

The truth about insurance rates has little to do with "minor injuries" and much more to do with the insurance industry's claims-handling tactics and their stated goal of achieving a better return on investment for their shareholders. The insurance companies told the Utilities and Review Board that they deserve a return on investment of 10%, approximating that of the banks, whereas they currently make a return closer to 8%. The difference, of course, between a bank and an auto insurer is that it is not against the law not to have a bank account.

These changes to the law in favour of the insurance companies will inevitably result in lower claims payouts to injured Nova Scotians and, hence, in higher profits for the insurance companies.

The image I'm left with is one of a group of insurance company executives just back from a meeting with Ron Russell, backslapping and bent double with laughter, saying, "You'll never *believe* what he went for!"

Oh, and by the way, that 20% rollback? Don't hold your breath.