Michael P. Taylor •
• Eric K. Grossman ~
Lisa Trabucco •
• William Sproull
Jennifer Griffiths •
• Heather Kawaguchi
Ian C. Lambert •
• Renata Bronshtein
Elizabeth Wilson •
• Nathalie V. Rosenthall
Dalia Fudim •
• Jim Dingwall

David Zarek •
• Thomas J. Hanrahan
Christine McKenna •
• Derek E. Wilson
Ryan M. Naimark •
• David Dinner
Ari Krajden •
• Peter Yoo
Mark L. Smith •
• Tanya Zigomanis
Jeremy Shaw •

~ Certified Specialist in Civil Litigation by the Law Society of Upper Canada

July 13, 2008

Mr. Willie Handler
Senior Manager
Automobile Insurance Unit
Financial Services Commission of Ontario
5160 Yonge Street
15th Floor, Box 85
North York, Ontario
M2N 6L9

Dear Mr. Handler

RE: FIVE YEAR REVIEW SUBMISSIONS

The below submissions are provided by the undersigned, with the assistance of my partner Jennifer Griffiths, and my associate Christine McKenna, and are a modification of a paper presented at the most recent Law Society Special Lectures on Insurance Law.

In the context of preparing a paper for the recent lecture, we were taken aback by how far removed the current system has devolved from the stated intentions of the government when implementing no fault insurance in the province of Ontario. Below, we have taken the opportunity to examine the system as a whole, and some of its component parts, and where possible, have provided critical comments as to how to improve the system.

There are still a myriad of difficulties in determining entitlement to specific benefits. While many of these are logistical and relate to the numerous roadblocks facing claimants and insurers alike as they try to comply with the increasingly impractical procedural requirements of the *Statutory Accident Benefits Schedule* (the "*Schedule*"), there are also a shocking number of unanswered questions relating to fundamental coverage issues, even though we are now over a decade into the Bill 59 era.

For example, the debate surrounding the meaning of "incurred" grinds on, as does the related question of what proof is required to document an ongoing claim for care or other services being provided by a non-professional service provider. The role of the fundamental insurance concept of

"indemnity" in determining access to coverage is entirely unclear.

The definition of what constitutes a "catastrophic impairment", a notion central to the ongoing "trade-off" between the availability of tort and no-fault coverage has been stretched beyond all recognition, creating an open and very costly question on all claims where anything beyond a trivial injury is reported.

Where there are legitimate differences of opinion regarding an insured person's entitlement to a certain benefit, access to dispute resolution is completely one-sided. Procedurally, there is little guidance for an insurer which disagrees with a DAC or insurer's examination, making these assessments practically binding on an insurer, with no similar constraints on an insured person. An insurer is essentially foreclosed from obtaining a second opinion when a problematic DAC or insurer's examination has been received, and thereafter, no way to initiate dispute resolution where it wishes to obtain direction from a judge or arbitrator regarding its ongoing obligations to an insured. Conversely, if an insurer relies upon a DAC or insurer's examination which is later found to have been incorrect in either its approach or its conclusion, the insurer faces exposure for any unpaid benefits, plus interest, plus the risk of a special award and/or damages.

The past eighteen years of no-fault coverage in Ontario has also not resulted in much headway in co-ordinating various kinds of coverage for loss of income in order to bring about fair recovery after a motor vehicle accident. It remains the case that "double recovery" is easily achieved where multiple policies of insurance are available, notwithstanding the relatively recent amendment permitting the deductibility of CPP benefits from income replacement benefits. At the same time, where an insured suffers severe disability but does not have tort rights or collateral benefits, no-fault coverage is woefully inadequate to meet lifelong needs.

In a related vein, absolutely no effort has been made to harmonize the operation of the *Schedule* with the provisions of the *Workplace Safety and Insurance Act* in order to promote fair and proactive handling of claims under the *Schedule*, as seems to have been contemplated by section 59 of the *Schedule*. Insurers who make payments in good faith where there is a potential section 59 defence, are left with no mechanism for collecting on a WSIB-approved assignment at the end of the day, even after having pursued lengthy and expensive proceedings before the Workplace Safety and Appeals Tribunal. By contrast, insurers who refuse benefits on the basis of section 59(1) are often successful in "forcing" insureds to activate their WSIB claim, with evident confusion even among FSCO Arbitrators as to whether FSCO has jurisdiction to deal with disputes where WSIB coverage has been acknowledged.

In addition to the legislative "gap" that clearly exists between the provisions of the *Statutory Accident Benefits Schedule* and other forms of disability coverage, there is also a lack of consistency in adjudicating claims advanced pursuant to the *Schedule*, depending upon whether the insured chooses to prosecute his or her claims before FSCO or before the Superior Court. This lack of consistency is in addition to the fact that FSCO lacks equitable jurisdiction to address extra contractual damages beyond the Special Award provisions in the *Dispute Resolution Practice Code*. These jurisdictional differences along with inconsistencies in adjudication throw a further level of

uncertainty into the mix for insured persons seeking fair and predictable interpretations of the *Schedule* as well as for insurers seeking to manage their costs and exposures.

As the procedural requirements governing the handling of accident benefits claims have become unmanageably complex, with adjudicators meanwhile demonstrating increasing liberality in the area of bad faith awards, insurers are justifiably concerned about controlling their costs in responding to questionable or contested claims for benefits. Even where the *Schedule's* procedural requirements have been followed to the letter, insurers still face vulnerability to a special award where an adjudicator may determine that the disposition of a claim, as supported by the available evidence at the time, was wrong. (See for instance *Yang and ING Insurance Company* (FSCO A05-000722; *Boyer and Allstate* (FSCO A03-001739); and *Rumak and Personal Insurance Company* (FSCO A01-000065) affirmed on appeal.)

Ironically, the highest awards and damages for unreasonable handling or bad faith in the accident benefits context have recently been dwarfed by several awards for interest pursuant to section 68 of the *Schedule*, granted on strictly contractual grounds, where no improper handling on the part of the insurer was alleged or found (See for instance *Attavar v. Allstate,* 2003 Can LII 7430 (Ont. C.A.))

Notwithstanding the Courts' continued insistence that the rate of interest set out in the *Schedule* is intended to be compensatory rather than punitive, recent awards of interest in the hundreds of thousands of dollars suggest that an "overdue" claim for benefits is the best investment that money can buy. With all of these issues far from a workable resolution, it must be concluded that while the statutory accident benefits scheme has grown up some in the past ten years, it has merely entered its teenage years – it may look like an adult but it still requires a good dose of common sense before it can be taken too seriously.

BILL 59: WHERE WE ARE NOW

Too Complicated by Half

An informal survey of professionals working on either side of the claims process in the current system will quickly elicit a long list of user complaints. From the perspective of claimants and their representative, the claims process is perceived as technocratic and complex, creating an increasing role for lawyers and paralegals who understand the machinations of the *Schedule*, but without providing any mechanism for that service to be compensated, except in catastrophic cases where a cash settlement can be anticipated.

The technical provisions of the *Schedule* impose equally unmanageable time deadlines on claimants and insurers alike in obtaining and forwarding information for the purpose of obtaining section 42 assessment referrals. For example, for a claimant there is the possibility that benefits will be suspended where he or she is not able to comply with a 5 day deadline to forward "relevant" documents to the assessor. Insurers, in turn, are overwhelmed with the volume of paperwork and the extremely short timelines in which to respond to funding requests and to complete referrals for insurer examinations. Procedural failures on the part of insurers necessarily translate into substantive

payment obligations, along with the risk of being found by the Financial Services Commission to have been noncompliant, or by a judge or arbitrator to have acted unreasonably in bad faith.

To the extent that section 42 of the *Schedule*, addressing insurer examinations, has now been given an increased role in the claims adjudication process, the availability of high quality assessments within the timelines mandated by the *Schedule* is also a chronic and serious problem.

The creation of various kinds of categories of claims (PAF, standard, catastrophic) has created the need for different handling procedures, which has sometimes resulted in an inappropriate, yet somewhat understandable, emphasis on form over substance in both adjusting claims and in adjudications before the Financial Services Commission.

Compounding these procedural challenges following the implementation of Bill 198, the removal of previous forms and procedures, such as those surrounding the stoppage of weekly benefits, has created a potential minefield of exposures for insurers and uncertainty for claimants. For example, the prior OCF 17 had been developed to provide the insured with "clear and unequivocal" notice of the insurer's position on entitlement, along with notice regarding the insured's right to challenge that determination. In its absence, we are now seeing quite *ad hoc* correspondence addressing the termination of weekly benefits under different circumstances, some of which provide the insured with clear and proper notice of the insurer's position, and some of which do not.

Procedures on top of procedures, ostensibly designed to streamline a now laughably unmanageable claims handling code are overtly failing. An effort to manage some of these processes by centralizing some portion of the document processing required on behalf of insurers with the creation of the Central Processing Agency is not off to an auspicious start. While the program was to have been rolled out to include all insurers licensed in Ontario by February 2008, it has instead been suspended from operation due to difficulties experienced by the Health Claims for Auto Insurance Processing ("HCAI") in "properly discharging its obligations", injecting even more chaos into the system for the short term.

While many layers of procedure have been piled onto the bare bones *Schedule* as it was introduced in 1990 (primarily in the name of consumer protection), little thought or effort has gone in to ensuring that insurers and their clients are receiving value for money in terms of the quality of services purchased with insurance funds. A cynic might suggest that the only stakeholders who have reason to appreciate the current regime are those who stand to profit from the various procedures now in place for assessing and processing claims. Certainly neither insurers nor accident victims have reason to celebrate the present state of affairs. It is a bit hard to understand how a considered effort to control the cost of auto insurance in Ontario while also providing a sensible balance between tort rights and a basic level of no-fault indemnification resulted in the manifold inefficiencies of the current system.

Whatever happened to the notion of indemnity?

Insurance, as a first principle, is intended to indemnify someone for a loss that they suffer. The statutory accident benefits scheme is both implicitly and explicitly structured around the notion of

indemnity. Originally being a system of providing accident victims with some immediate relief to fund accident-related expenses regardless of fault, the wording of successive incarnations of the *Schedule* has continued to include coverage for "reasonable and necessary expenses incurred by or on behalf of the insured" for various goods and services including childcare, dependant care, attendant care, housekeeping and home maintenance, transportation costs and medical and rehabilitation expenses. However, the treatment of this language by decision makers has significantly departed from the interpretation a layperson would give to the definition of "incurred", and is still the source of uncertainty and confusion in the claims process, eighteen years after the advent of no-fault insurance in Ontario.

The Court of Appeal addressed the nature of statutory accident benefits coverage in this regard in the 1999 ruling in *Monachino v. Liberty Mutual* (2000), 47 O.R. (3d) 481 (Ont. C.A.), decided under the OMPP *Schedule*. In that case, the trial judge had denied funding for care services provided by a family member who had not lost income in order to care for her disabled child, with the claim being advanced under either section 7 1(a) or (b) or section 6(i)(f) of the OMPP *Schedule*. [1997] O.J. No. 3571 (Ont. Gen Div.). In addition, a declaration for entitlement to funding for a future plan of care was rejected at trial. The Plaintiff argued that the actual value of services provided by an unpaid family member to her child were compensable either as "reasonable expenses resulting from the accident in caring for the insured person after the accident" or as "other goods and services" which the insured person required as a result of the accident. The trial judge, while finding that the language of the *Schedule* did not actually mean that money had to have been paid out by the insured, ruled that it was still necessary establish that liability for the costs had been assumed by the insured in order to have the expense deemed to have been incurred.

The trial ruling was upheld before the Court of Appeal, who rejected the Appellant's argument that the relevant sections of the *Schedule* should be "interpreted liberally in order to give relief in a meritorious case." Instead, the Court of Appeal agreed:

> *There are three preconditions to entitlement; a cost must be incurred, it must be reasonable and it must be for a professional caregiver. To accept the appellant's interpretation would be to rewrite the statute instead of applying its clear language*.

The Appellant went on to argue that the use of the word "expenses" in the statute simply meant that a cost had been "incurred" by the actual provision of services to the insured, even in the absence of a payment or promise of payment. The Court disagreed once again:

> *Care giving services by members of a loving family are not an expense or a cost in the contemplation of this statutory framework. They can sometimes be compensated for in other areas, such as under the Family Law Act in a proper case, but they do not fit within the language of the sections of the no-fault schedule we are dealing with.*

In concluding this section of the appeal judgment, the Court went on to explain its refusal to go beyond the language of the sections under consideration in order to take a purposeful approach:

In any event, I would be reluctant to second-guess the framers of this no-fault scheme with respect to this item in isolation. We are not aware of the social and economic considerations that went into the decisions to provide the various benefits in the program. It would be a mistake for this or any other court to engage in what would amount to no more than tinkering with the regulation where we have no evidence of the cost significance of what is being put forward by the appellant. This position is consistent, I think, with what this court said about no-fault insurance in ***Meyer v. Bright*** *(1993), 15 O.R. (3d) 129 at p. 134:*

> *In our view, the Ontario legislature enacted s. 266 and other related amendments to the act for the purpose of significantly limiting the right of the victim of a motor vehicle accident to maintain a tort action against the tortfeasor. The scheme of compensation provides for an exchange of rights herein the accident victim loses the right to sue unless coming within the statutory exemptions, but receives more generous first party benefits, regardless of fault, from his or her own insurer. The legislation appears designed to control the cost of automobile insurance premiums to the consumer by eliminating some tort claims.*

The Court of Appeal went on to affirm the trial judge's refusal to provide declaratory relief in respect of the future care costs that were presented at trial, stating:

> *As explicitly stated by the trial judge, the injured party has the right to present specific proposals for intended treatment and services for consideration and approval by the insurer and those claims will be paid as the costs are incurred and the services are provided.*

This portion of the ruling again emphasizes the necessity for expenses to have actually been incurred *before* the payment provisions of the *Schedule* will apply to an identified claim.

Subsequent amendments to statutory accident benefits coverage have permitted compensation for attendant care provided by family members. What has followed this ruling is over a decade of rather overt "tinkering" with the explicit language of the *Schedule* on this point. Initially the Financial Services Commission seemed to follow the *Monachino* approach in interpreting the word "incurred" in the no fault context. In each of *Morelli and Zurich* (FSCO A97-001997) and *Jelisic and Guarantee* (FSCO A98-000029) in order for an expense to have been "incurred" the insured was not required to have made a payment for which reimbursement was sought. However, there had to be cogent or objective evidence that the applicant "incurred" the expenses in question by, at the very least, a promise to pay.

More recently, this approach to the definition of "incurred" has clearly fallen by the wayside, starting at the Financial Services Commission. In the decision *L.F. and State Farm* (FSCO A00-B-000364) Arbitrator Blackman held that for an expense to have been incurred, there did not have to be a promise to pay or an expectation of payment on the part of the provider. All the insured had to demonstrate was that the expense was reasonable and necessary. This aspect of the case was upheld on appeal, although it must be noted that the ultimate determination of entitlement in this instance turned heavily upon the emerging authority upon the "duty to inform".

In the FSCO appeal level ruling in *Stargratt and Zurich* (FSCO P01-00045) Director's Delegate Makepeace discussed the level of documentary evidence that would be required where care is provided by family and friends pursuant to informal arrangements. The arbitration and appeal rulings treated the "reasonable necessity" of the services in question as central to the issue of entitlement, with there being no requirement to prove that money was owing for these services. At the same time, there was still a requirement to establish that the services were received since this evidence would be the most straightforward way of demonstrating that the services were necessary. In this regard, the Director's Delegate stated as follows:

> *Insurers are entitled to require documentation of caregiver and attendant care services claimed, and they have reason to ask more questions when family members provide the services. Although detailed, contemporaneous record keeping is ideal, evidentiary requirements should be tailored to the informal context.*

While generally endorsing informal arrangements between family and friends for the provision of attendant care at modest hourly rates, the Director's Delegate made an overt link between the insurer's duty to inform an insured of claim documentation requirements to the level of proof that will be required in any given instance. She noted that, if the insurer in this instance had provided sufficient information regarding the benefits payable and the procedure for accessing these benefits, the failure to provide adequate records could have hampered Ms. Stargratt's claim. Nonetheless a special award was found warranted at first instance in this case and upheld on the appeal.

More recent decisions have moved even further from any common sense definition of what it means for an expense to be "incurred", to extend funding in cases where there was no promise to pay, no out-of-pocket expenditure, and furthermore, no provision of goods or services.

In the case of *McMichael and Belair* (FSCO A02-001081); (FSCO P05-00006), the insurer had refused attendant care, taking the position that the insured's crack cocaine addiction did not constitute an "impairment" for which it was in law responsible, and which did not have sufficient causal connection to the motor vehicle accident. As a consequence of this position, Mr. McMichael did not receive attendant care, pay for it, or incur a debt or obligation to pay it. The arbitrator nonetheless awarded a payment for past attendant care, plus interest on the "unincurred" expenses at the rate stipulated in section 46 of the *Schedule*. In upholding the decision, Director's Delegate Makepeace reasoned that the accident benefits scheme is consumer protection legislation and that this sometimes requires "bright line boundaries" that produce "anomalous" results. The insurer should not be able to benefit from refusing a service that was reasonably required and accordingly an award of attendant care was warranted.

The *McMichael* ruling was recently upheld on judicial review. Justice Lane writing for the Divisional Court pointed to arbitral jurisprudence which had shown a trend towards a "purposive and remedial approach" in interpreting the various *Schedules* (in direct contradiction to the Court of Appeal's statement on this point in *Monachino*). A two pronged test was proposed in this case for determining whether an expense had been incurred for the purpose of the *Schedule*. First, one must establish the reasonable necessity of the service or item, and, second, prove that the amount of the expenditure can be determined with certainty.

The *McMichael* case simply proves the old adage that bad facts make bad law. While the disposition in this case suggests that there is no longer the slightest need to prove that claims of any kind reflect actual goods or services received or expenses incurred (but merely that the need for same was reasonable, whether met or unmet), such an interpretation is obviously totally inconsistent with the *Schedule's* procedural code and would be a risky guiding principle for claimants to follow. It also takes the first principle that insurance is to provide indemnity for damages suffered and losses incurred, and disregards it completely.

Concurrent with this development however, the FSCO appeals ruling in *Fernandes and Certas* (FSCO P06-00030) has recently been released, addressing the adjudication of attendant care claims and the role of the Form 1 in establishing entitlement. In that case, a Form 1 prepared on behalf of the insured had calculated attendant care needs at over $5,000 per month. The insured was residing in a care facility, and the issue at arbitration related to the services that were reasonable and necessary, over and above those which were being provided by the facility. The insurer had not obtained a competing Form 1 assessment. The Arbitrator conducted a line-by-line review of the Form 1 based upon the evidence, and concluded that only a fraction of the services listed on the Form 1 were in fact "reasonable and necessary." On appeal, the insured argued that the mandatory language of the *Schedule* stating that attendant care entitlement "shall" be determined in accordance with a Form 1 compelled the insurer to pay the rate stipulated by the insured's Form 1 in the absence of any competing Form 1. Director's Delegate Blackman disagreed, stating that the reasonable necessity of services still needed to be proven on the evidence, following which covered services would be payable in accordance with the amounts set out in the Form 1 for those services:

> *I agree with Arbitrator Skinner, in McKnight and Guarantee Company of North America (FSCO A02-000299, October 28, 2003), that subsection 16(4) of the Schedule:*
>
> > *. . . requires the benefit to be paid in accordance with the amounts set out in the Form 1, only once entitlement to the benefit has been established . . .Subsection 16(2) of the Schedule contemplates that an attendant care benefit is to be paid for reasonable and necessary expenses incurred. The Form 1 identifies attendant care needs, but does not constitute evidence that expenses have been incurred.*

Taken together, the *Stargratt* and *Fernandes* decisions would seem to indicate that, where an insurer has taken appropriate steps to advise the insured person of their right to claim attendant care benefits and outlined appropriate documentary requirements to establish the reasonable necessity of the service (if not the expense), benefits are thereafter payable to a maximum of the amounts set forth on the Form 1, if "reasonable necessity" of the particular expenses is demonstrated. Failure to provide documentary or other evidence that the service is in fact being received in accordance with the Form 1 will undermine the insured person's position that the service is "reasonably necessary."

The *Fernandes* decision in particular suggests a common sense approach to adjudicating attendant care claims, even while the definition of "incurred" seems to be somewhat flexible depending upon the circumstances of the case. If proof that a service has been provided (and therefore some form of transaction has taken place regardless of whether payment or the promise of payment is involved)

will establish the reasonable necessity of the Form 1 rates claimed for that service, it stands to reason that the absence of such evidence will undermine the claim, even where a Form 1 identifies a recommended service.

This emphasis on "reasonable necessity" rather than the exchange of funds or the amounts stipulated on a Form 1 as the basis for finding entitlement may be consistent with the disposition of the attendant care claim (in the tort context) in *Desbiens v. Mordini* [2004] O.J. No. 4735 (S.C.). In that instance, the Plaintiff presented a Form 1 attendant care assessment recommending overnight supervision for Mr. Desbiens, to ensure his security in the event of an emergency. In considering this claim, Justice Spiegel commented as follows:

> *Thus the overnight security component of Mr. Desbiens' attendant care needs is greater than all the other components put together. I must confess that the expenditure of this amount of money to guard against the occurrence of an emergency, which on the evidence has never occurred in the 18 years that Mr. Desbiens has lived in the apartment as a paraplegic, seemed to me to be grossly excessive.*

In other words, although this need was identified in the Form 1 before the Court, Justice Spiegel could not accept the "reasonable necessity" of the proposed costs or services. Because the Defendant did not adduce evidence of other "common sense" solutions which would meet the Plaintiff's security needs without the need for an overnight attendant, the Court permitted the overnight care recommended, but at a rate of only $8.00 per hour, consistent with the kind of costs that the Plaintiff would actually incur if he purchased the services himself.

While it is important to remember that the comments on this point in *Desbiens* took place in a tort context, the recent developments in the case law before FSCO suggests that Arbitrators will not be slavish in their adherence to Form 1 evaluations in looking at the "reasonable necessity" of attendant care claims. Within this context, it will be interesting to see what may happen in the area of overnight care claims before FSCO, where a Form 1 may suggest that overnight supervision would be reasonable, but no actual services are necessary given the particular living arrangements of an insured.

From an accident benefits claim perspective, it is clear that, where the insurer fails to provide the insured with information necessary to access available benefits, the standard required of the insured in documenting his or her claim will be reduced. Proof of the reasonable necessity of an expense will be required beyond the Form 1 evidence in certain circumstances and therefore the need to document claims presented still exists. This makes good common sense, depending upon what the precise content of the insurer's duty to inform is ultimately found to be.

At the same time, there can be no doubt that the "reading out" of the words "expense" and "incurred" from the *Schedule* in the *McMichael* decision as well as the subsequent appeal decision in Michalski and Wawanesa (FSCO A03-001363);(FSCO P06-00003) creates a problematic precedent. In *McMichael*, an expense was found to be payable under the *Schedule* even though there was no argument that it had been incurred; only required. In *Michalski* (as upheld on appeal) the Arbitrator relied on the reasoning in *Stargratt* to determine that the insured was entitled to attendant care

benefits retroactively even where it appeared that there were periods of time when those benefits would not have been payable at the highest assessed rate, but again the insurer was found to have breached its' duty to inform the insured of her rights.

It is suggested that, while the findings of fact in each of *McMichael* and *Michalski* justified some form of remedy to the insured, they did not support the conclusion that an expense had been "incurred", within the specific language of the *Schedule*, when the insured's complaint was essentially the opposite. The ultimate disposition of each of these cases (particularly *McMichael*) came about at the expense of some very tortured language, creating precedent in the form of an outcome that the Director's Delegate herself described as "anomalous."

Where a trier of fact finds that an insured has gone without services as a result of an insurer's contractual breach, and a remedy is spelled out within the contract, it is inappropriate to read one into the language of the contract. In the context of a Court proceeding, extra-contractual damages are available. Before FSCO, the availability of a Special Award is of limited effect due to the restrictions on the dollar amount that can be granted. Certainly the amount of a special award will not compare to the amount of interest that is awarded where benefits are found to have been "overdue" for an extended period of time.

If FSCO Arbitrators lack the jurisdiction to address extra-contractual losses appropriately, this is a matter that should be addressed at the legislative level, and not in the form of *ad hoc* decisions of questionable precedent value.

In April 2008 The Court of Appeal in *Monks v. ING* expanded the availability of declaratory relief in the no fault era post 1990, despite the earlier pronouncement in *Monachin*o. In Monks, The Court referred to a much earlier Court of Appeal decision in *Coombe v Constitution* (1980) 29 O.R. (2d) 729, pre-dating the no fault era where accident benefits were much more modest than they are today. In Coombe, the court granted a declaration in respect of weekly no fault benefits of $140 per week on the basis that the insured should not have to continuously establish entitlement to benefits on a week by week basis after the disability was proven at trial

Where ING had ceased paying benefits to Ms. Monks as of May 2002, the Court of Appeal found the case was not similar to Monachino, and found that Ms. Monks was entitled to the protection of a declaration of entitlement, speaking to the "reasonable necessity" of goods and services outlined in a future plan of care which had been put before the court in the context of the aggravated damages claim. The trial judge ordered that the Ms. Monks would still have to substantiate specific expense claims, but would not need to prove that her expenses were reasonable and necessary on a go forward basis. It would be for ING to prove that the claims were not reasonable and necessary if it chose not to honour the claims. The Court of Appeal found that this approach was in keeping with Coombs, which remains good law.

The effect of the *Monks* decision could be profound. Whereas accident benefit insurers could previously rely on the court's disinclination to order that future accident benefits be paid out in a lump sum, *Monks* may create a significant departure from this. Where there is no longer a need to prove that an expense has been or will be incurred, and where a declaration of future entitlement

might be granted, an insurer may have little opportunity to obtain and lead evidence to vary a declaration order in the future, thereby effectively making the declaration tantamount to a final word on the claim.

We predict that the current state of the law respecting "incurred" could very well lead to the next insurance crisis. A tightening of this definition will be necessary, failing which, following *Monks,* insurers will be facing huge pressure, to have declarations granted compelling life long payments in cases which are far more questionable than they were in *Monks.*

The Evolving Threshold of "Catastrophic Impairment"

With Bill 59, a two-tiered system of no-fault coverage was introduced in Ontario. For individuals who met the "catastrophic definition", an enhanced level of accident benefits was available to meet health care costs, and the right to sue for these expenses was available to innocent accident victims. With Bill 198, the right to sue for health expenses has been restored for all innocent accident victims, although the catastrophic designation on the accident benefits side still determines the level of coverage available for medical and rehabilitation, attendant care and housekeeping expenses.

By far the most influential decision interpreting the catastrophic threshold to date is that of Justice Spiegel in the case of *Desbiens v. Mordini*, in which he described the purpose of the two-tiered system as follows:

> *Indeed, a common thread runs through the remarks quoted above. That is, the intention to restore fairness to the system for the innocent victims of motor vehicle accidents. Thus a major purpose of section 275.5(5) of the Act is to ensure that those innocent victims who are in the most need are able to recover health case expenses, perhaps at the expense of those who have less need. The legislature appears to recognize that catastrophically impaired plaintiffs are a special case, and health care costs can be enormous. Another important purpose was to control premiums. In my view, however, insofar as health care expenses are concerned, this was to be achieved by the drastic reduction in the level of medical and rehabilitation benefits available on a no-fault basis*

In order for this purpose to be met, it is necessary for the catastrophic threshold to be interpreted in a meaningful manner, that extends a higher level of coverage to those who meet the threshold, while restricting the potential claims of those whose impairments fall below the catastrophic standard. There is no doubt that the concept of what constitutes a catastrophic impairment has enlarged considerably since the definition was first introduced in 1996, extending catastrophic coverages quite predictably wherever catastrophic level coverage needs are established in the evidence. This trend is unmistakable, notwithstanding the protestation by decision makers to the contrary.

In the *Desbiens* case, Justice Spiegel used this approach to justify the assigning of percentages to psychological impairments described at Chapter 14 of the *AMA Guides*, in order to quantitatively combine them with physical impairments to reach the 55% Whole Person Impairment threshold for catastrophic designation. According to Justice Spiegel:

While Bill 59 allows only those who have suffered a catastrophic impairment to recover health care expenses in my view, the text of the Regulation itself indicates that the drafters clearly intended the definition of "catastrophic impairment" to be inclusive rather than restrictive.

After analyzing the *AMA Guides*, Justice Spiegel determined that the assignment of percentages to psychological impairments was in accordance with the *Guides*, and was justified on a purposive approach to the Regulation in any event, stating that his approach:

...gave effect to the purpose of the legislation and gave the benefit of the doubt to the insured. In Bill 59 the restoration of the right of innocent persons who are catastrophically impaired to sue for health care expenses was balanced by reducing the health care benefits available under the SABS to those not catastrophically impaired. In my view, there was no balancing involved in determining what constitutes catastrophic impairment under clause (f) or (g). Nor can it be said that if one looks at the complete package, there was a justifiable exchange of rights under Bill 59 so far as the seriously injured plaintiff was concerned. Under Bill 164 all persons in need of health care expenses were entitled, on a no-fault basis, to a maximum of $1,000,000 in medical rehabilitation benefits and attendant care benefits with no overall maximum. This was reduced in Bill 59 to $100,000 for medical rehabilitation and $72,000 for attendant care. Thus Bill 59 gave catastrophically impaired innocent victims the right to sue for health care expenses, which in the vast majority of cases, they could have recovered on a no-fault basis under Bill 164 and also drastically reduced the benefits for the at fault injured person.

The FSCO decision in *G. and Pilot* (FSCO A04-000446) built upon the approach taken in *Desbiens*, particularly in relation to what it means to determine a Whole Person Impairment "in accordance with" the *AMA Guides*, which are referenced in the *Schedule* as the basis for determining whether the 55% Whole Person Impairment catastrophic threshold at section 2(1.2)(f) is met. Arbitrator Blackman identified a number of difficulties in working with the *Guides* for that purpose as follows:

....An impairment percentage derived by means of the Guides is intended, among other purposes, to represent an "informed estimate" of the degree to which an individual's capacity to carry out daily activities has been diminished. The Guides note that they do not cover all conditions arising out of injuries. They further state that while medical information is essential for the decision process, the key is the interpretation and use of the medical information. The critical problem, state the Guides, is that there is no formula known by which to combine knowledge about a medical condition with non-medical information about one's personal, social, occupational and other activities of daily life. The Guides specifically state that while they can help in such areas as workers' compensation, they "cannot provide complete and definitive answers."

The Guides further caution as to their reliability by strongly discouraging the use of any but the most recent edition of the Guides. The Guides are now more than a decade old, and have been replaced by further editions. The Schedule, however, dictates adherence to the outdated Fourth Edition, but with the proviso at paragraph 2(1)(3) that an "impairment that is

sustained by an insured person but is not listed in the [Guides] shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person."

The Guides strongly state that the impairment percentages derived from the Guides criteria should not be used to direct financial awards or make direct estimates of disabilities. However, as noted both in Desbiens v. Mordini [2004] O.J. No. 4735 and Snushall v. Fulsang [2003] O.J. No. 1493 (S.C.J.), "the insurance legislation in Ontario appears to require precisely what the Guides themselves discourage."

Having identified these multiple difficulties in using the *Guides* to determine whether the catastrophic threshold has been met, Arbitrator Blackman went on to state his view that the use of the *Guides* in this context involved an adjudicative rather than a medical determination, and therefore:

The trier of fact is not simply reduced to choosing between expert medical opinions. The trier of fact, rather, has the responsibility under paragraph 2(1)(f) of the Schedule to endeavour, in accordance with the rules of statutory interpretation, to capture and accurately estimate all of the impairments that an insured person has sustained as a result of the accident. [67] *[emphasis added]*

In other words, the provision in the *Schedule* which directs that a whole person impairment analysis be conducted in "accordance with" the *AMA Guides*, is to be reduced to a process whereby the *Guides* are used as a basis for the impairment estimate, with departures from the *Guides* where strict adherence would not "capture and accurately estimate all of the impairments that an insured person has sustained as a result of the accident."

In the recent FSCO decision in *H. and Lombard* (FSCO A06-000209) the manner in which psychological and physical impairments were to be assessed under the *Schedule* was considered. In that case, the evidence supported the conclusion that the insured's physical injuries were overall, less disabling than her post-accident psychological problems. Arbitrator Renahan reviewed his prior comments in *George and State Farm* (FSCO A03-001062) , in which he had noted the explicit exclusion of percentage impairments for mental and behavioural conditions from the 4th edition of the *AMA Guides*. On this point, he made the following inconclusive statement:

The authors of the Guides considered that one valid reason for assigning percentage ratings for mental impairments was to make the chapter on mental disorders consistent with the Guides chapters for the other organ systems. They decided against it for the reasons I have described. The direction in the Guides not to convert a mental or behavioural impairment into a percentage WPI is clear to me. However, in the recent decision of Pilot Insurance Company and Ms. G, (FSCO Appeal P06-00004, September 4, 2007) Director's Delegate Makepeace agreed that it was appropriate to assign a percentage WPI to an impairment based on a mental or behavioural disorder and combine that with a percentage WPI due to a physical impairment.

The Arbitrator went on to find that Ms. H. met the catastrophic threshold on the basis of a "marked"

impairment in social functioning alone, and added that if he had to arrive at a whole person impairment rating, the allocation for mental and behavioural impairment would be "at least" 55%, although an analysis supporting this figure is not provided in his decision. Likewise, there was no discussion surrounding the question of whether there must be a Class 4 or 5 impairment in more than one sphere in order to establish catastrophic status pursuant to subsection (g) which addresses mental and behavioural impairments alone. Implicitly, however, the Arbitrator accepted that it was sufficient for a marked impairment to be found in only one sphere.

The approach to catastrophic designation pursuant to paragraph (g) of the definition should remain a live issue, notwithstanding the extremely liberal rulings on this point to date. A careful review of Chapter 14 of the *Guides* clearly indicates that in order to have a Class 4 impairment, one must be found to have a class 4 impairment in at least two spheres. However, in *Desbiens*, Justice Spiegel noted that the parties *agreed* it was enough to have a Class 4 or 5 impairment in only one realm (such as employment activity), to be deemed catastrophic pursuant to the definition at section 2(1.2)(g).

The hearing arbitrator in the case of *Belair and McMichael* also concurred with this premise, although this issue does not appear to have been extensively canvassed in that case. While noting that a FSCO guideline entitled "Mental and Behavioural Impairments Assessments Guideline" required a class 4 or 5 impairment in two or more functional areas, the arbitrator found the FSCO guideline was not binding on him. The arbitrator's decision was upheld on appeal and on judicial review although this particular issue was not addressed again. Arbitrators at FSCO have now begun to accept catastrophic designation on the basis of one sphere of marked impairment, without even providing reasons for doing so as in the case of *H. and Lombard*.

In effect through *Desbiens*, one decision by a single judge has greatly expanded the definition of a catastrophic impairment. The most troubling aspect of this decision is the failure of the judge to properly review the *AMA Guides* themselves. Furthermore, it appears that the *AMA Newsletters* were not referenced in the decision and so were not used to assist in Mr. Justice Spiegel's interpretation of the *Guides*.

Where there is now the 6th edition in print, and where this edition does a much better job of including mental and behavioural impairments as part of a whole person assessment, it makes little sense to maintain usage of the outdated 4th edition. Moreover, where objective measures in the health care system exist to determine when someone has suffered a catastrophic impairment (try getting admitted to a hospital for a period of 5+ days without having a serious injury) it is unclear why these types of milestones are not being looked at.

Procedural Hurdles

A cursory glance through the Bill 59 *Schedule* particularly following the Bill 198 amendments will persuade anybody that the procedure to be followed in adjusting an accident benefits claim are now unmanageably complex. The sections dealing with medical assessments on the claim, for example, run to several pages in length, and mandate time lines that are simply not realistic assuming any kind of an arms length relationship between insurers and potential assessors. The insured is given five days to supply "all reasonably available information and documents that are relevant and necessary

for the review of the insured person's medical condition" to the person conducting the examination. Failure to provide this information will result in the suspension of benefits. The *Schedule* does not indicate what kind of information is "relevant" or how an insured is supposed to obtain these records within the prescribed timelines. The costs of obtaining this information are presumably borne by the insured on an immediate basis.

Ironically, the claims processing challenges (for both the insurer and claimant alike) are greatest at the more modest end of the range, where the costs associated with managing these claims are less justifiable relative to the potential value of the claim. For example, where a claim originates within a Pre-approved Framework ("PAF") structure, there ought to be no reason to "adjust' on an ongoing basis for potential attendant care exposures. Indeed, there would arguably be no basis for seeking a section 42 assessment of attendant care needs in the absence of such claims. However, this does not anticipate a situation in which a subsequent assessment at the insured's behest supports a non- PAF designation, in which case, coverage for attendant care is restored, and the insurer is left responding to an "exposure" in the absence of any ongoing assessments addressing its merits.

The complexity of the *Schedule* makes it increasingly necessary for accident victims to obtain legal or paralegal assistance in advancing their claims. It is submitted that where small and medium sized claims are concerned, the only way accident benefits claims can be handled in a remotely cost effective manner is through the use of highly expert, specialized, high volume operations whether this handling is on behalf of insurers or claimants. This is a far cry from the simple and expeditious process that was contemplated when FSCO was brought into being.

It must be acknowledged that the consequences of procedural non-compliance are much more severe for insurers than for insured persons, for whom relief from forfeiture (under whatever guise) is generally available. The *Schedule* sets out timelines and procedures for the orderly submission and documenting of claims, and then stipulates that the relief from these provisions is available wherever the insured has a "reasonable excuse" for failing to comply. What constitutes a "reasonable excuse" had been construed broadly indeed. To a large extent, this imbalance is understandable: insurers are presumed to have a greater sophistication and more resources than accident victims and should therefore be held to a high standard of proficiency in handling claims. At the same time, as the procedures keep changing and the content of the insurer's duty of good faith is expanded with each successive ruling on the subject, it becomes increasingly difficult to achieve that proficiency, even with sincere good faith efforts. Insurers are hard pressed to find, train and retain competent adjusters, where morale of the most well intentioned and competent accident benefit adjusters can be irreparably harmed by repeated castigation by opposing counsel, including actions against them personally, and often by decision makers.

There is not sufficient time or space to document all of the procedural impracticalities involved in dealing with claims following the Bill 198 amendments to the *Schedule*. However, we do want to devote some attention to particular ways in which the procedural code appears to be on a collision course with the expanding content of the insurer's duty of good faith in a first party context.

Succinctly, the procedural code in the *Schedule* presumes that certain events will occur in a certain order in the course of a claim being advanced. Many of the cases referred to elsewhere in this article

involve adjudication of a claim where the history between the parties has not proceeded in this manner, for one reason or another. It is obviously these problematic cases that give rise to disputes and thereafter to adjudications and then to the kind of "anomalous" decisions that create immense challenges in subsequent cases.

Section 42, for example, sets out the right of an insurer to obtain an assessment of its insured by a health practitioner of its choosing "[f]or the purpose of assisting an insurer determine if an insured person is or continues to be entitled to a benefit under this Regulation **for which an application is made** (emphasis added)." This section presumes that the "making of an application" is an easily identifiable event in the course of a proceeding, although the ruling in *Michalski* and other cases, suggests that what constitutes an "application" which gives rise to a payment obligation may depend upon the circumstances of the case.

Insurer examinations are recognized as inherently intrusive, and case law addressing the availability of such examinations has indicated that there is a balance to be achieved in protecting the privacy of the insured, while also permitting the insurer an opportunity to assess and adjust the claims being advanced. (See *Ali-Shimasawi and Wawanesa*, FSCO A05-02737). It is in recognition of the need to minimize the intrusive aspect of these examinations that adjudicators have taken a "bright line" approach to the notice requirement under section 42, finding that notice complying with the section cannot be waived, and that what constitutes "proper notice" will be strictly and technically construed. (See *Ives and Wawanesa Mutual Insurance Company*, (FSCO A05-02144).

Consistent with this line of cases, claimants often refuse to attend insurer's examinations where the stated "reasons" for the examination may pertain to a category of benefits that have not been the subject of a formal "claim," and generally take the position that a section 42 examination addressing disability may not comment upon treatment needs on this basis. If indeed the insured person is receiving medical management and is submitting claims proactively on an ongoing basis, this position makes sense. If, however, the insurer is expected to act as both a source of funding, and a source of advice and information about potential claims (consistent with the direction in the "duty to inform" cases), restrictions on the scope of insurer's examinations are potentially very problematic.

With hindsight always operating at 20/20, an insured person who alleges that an insurer had provided insufficient information about the benefits potentially available will often be in a position to advance claims retroactively. This may be the case even where the insurer did not have enough knowledge of the insured's circumstances to provide that information If a liberal and remedial approach to these kinds of cases continues to be taken, the insistence that insurer's examinations must proceed in a piecemeal fashion based upon particular claims formally advanced at the time seems counterproductive. Surely if an insurer may later be deemed to have "known" about potential entitlements based upon very limited information provided at the outset of the claim, having access to proper assessments addressing the insured's needs more broadly defined would help the insurer in its duty to inform, and facilitate the claims process.

Ironically, the goal of minimizing the intrusion of these examinations is also defeated if examinations can only be conducted in response to formal advanced claims, given that there is

seemingly no restriction on the number of assessments that can be conducted under section 42, provided that the assessment is deemed to be "reasonably necessary" "to determine if the insured person is or continues to be entitled to a benefit." A more sensible approach might be to permit insurer's examinations to address entitlement to claimed and potential benefits, but to restrict the frequency at which such examinations can be conducted.

Section 42 and the predecessor DAC provisions are also problematic in that they do not provide any means of obtaining redress or clarification where an insurer has concerns regarding the quality or reliability of an expert report. While an insured person can challenge an assessment through litigation or arbitration, an insurer apparently cannot initiate either. This has been an area of particular concern in the realm of catastrophic assessments. Full catastrophic evaluations typically cost insurers upwards of $20,0000 and either permit or foreclose entitlement to enhanced coverage levels for life. Assessments under the different criteria for catastrophic impairment set out at section 2(1.2) of the *Schedule* necessarily involve a multi-disciplinary approach, and in the case of the definition at paragraph (f), the use of a highly technical process in addressing whole person impairment evaluations under the *AMA Guides*, a process not otherwise in wide use in Ontario.

There has been a longstanding practice of obtaining a "DAC critique" report where the outcome of a DAC was not accepted by either side. Although these "critique" reports were not mandated by the DAC-era *Schedule*, they were generally (in the case of those reports obtained by insurers) paper reviews only, and were obtained for the purpose of evaluating the possibility of attempting a formal challenge of the CAT DAC. Critique reports based upon paper reviews were relied upon in a number of CAT DAC challenges dealing with the GCS of 9 or under criterion, without the procedural status of these reports being scrutinized in any way.

However, now that there is a particular procedure in place pursuant to section 42 of the *Schedule* for an insurer who wishes to obtain a paper review, it is not clear on what basis an insurer can obtain a second opinion where there is a concern about the correctness of a catastrophic determination. In the case of a "DAC critique" it is fair to argue that the DAC is a neutral body and an insurer has a right to a second opinion, if it is felt that the DAC may have made an error. However, it is not clear whether a paper review critique can technically be obtained without following the provisions of section 42.

This creates a catch 22 situation for insurers. If an insurer receives a CAT DAC which appears to be flawed, it is bound to follow the result on an interim basis. Furthermore, as a matter of good faith, it would be inappropriate to resist a catastrophic determination (whether in the form of a CAT DAC or an insurer's examination) without some good (i.e. expert) reason for doing so. However, it is far from clear how such a report can be obtained post March 1, 2006, using the procedural provisions of the *Schedule.*

Even where an insurer has evidence sufficient to challenge a DAC outcome, the Ontario Court of Appeal in *Liberty v. Fernandes* (2006), 82 O.R. (3d) 524. has ruled that there is no mechanism for it to do so. While it is clear that insurers have no right to access Arbitration before FSCO, it was generally presumed that insurers retained a common law right to seek judicial direction regarding their contractual obligations. However, the Court of Appeal found that sections 279 to 283 of the *Act*

as read in its entirety, provides a full code governing an insurer's access to dispute resolution, which does not include the right to commence litigation. Pursuant to section 281 of the *Act*, for an insurer to challenge an adverse DAC determination, it first must apply for mediation on the issue, and thereafter must pay benefits in accordance with its last offer at mediation. It is thereafter up to the insured to access arbitration or litigation challenging that position, through which process the insurer can challenge the CAT DAC determination.

Writing for the Court, Madame Justice Feldman concluded:

> *Consequently, the onus is always on the insured to initiate dispute resolution after a failed mediation in order to seek any additional benefits that may be warranted by the CAT DAC. If the insured does not act, the insurer will only pay benefits in the amount at which it was prepared to settle. The insurer is thereby protected and need not pay the additional benefits to which it objects unless so ordered through the dispute resolution scheme. The insured is similarly protected as it has the right, pursuant to s. 281(1), to commence litigation or arbitration to try to obtain the benefit of a favourable CAT DAC finding.*
>
> *By leaving the choice of forum always with the insured, the legislature has guaranteed that the insured maintains control of the process including its timing and cost. See Baron v. Kingsway General Insurance Co. (2006), 35 C.C.L.I. (4th) 180 (Sup. Ct.) at para. 29. Arbitration under the Act is an expeditious and much less costly process than a court action, but the court option is open to an insured. At the same time, s. 281(5) (now s. 281.1), protects the insurer from any undue delay by the insured in initiating dispute resolution, by providing a two-year limitation (subject to the SABS) following an insurer's refusal to pay a claimed benefit, for a step to be taken under s. 281(1).*

This ruling caused significant concern to the insurance industry for at least two reasons. First, it is disconcerting to be told after more than fifteen years that something as basic as the right to obtain judicial interpretation of contractual obligations under the *Schedule* does not exist and never has. Moreover, it is surprising that the Court of Appeal could describe the insurer as "protected" after it makes an offer at mediation and then proceeds to pay in accordance with its position while waiting for the insured person to access dispute resolution some time in the following two years. While the ruling in *Fernandes* may well be a defensible, or even correct interpretation of the *Insurance Act* (whether or not it was correct as it relates to common law rights of a party to a contract), to describe this procedure as in any way "protecting" an insurer's interests suggests that the Court had never read its own decision in *Attavar*, or did not have a calculator handy at the time to establish how unprotected an insurer is, when dealing with interest that compounds at a staggering rate. A claimant's lawyer would be borderline negligent to move expeditiously to litigation or arbitration following a mediation process as described in *Fernandes*, thereby foregoing the prospect of recovering interest at 2% per month compounded monthly on any claims proven thereafter, whether costs had been incurred in the interim or not.

FSCO vs. Court?

Should the insured person proceed to challenge the insurer's last offer at mediation, there are both procedural and substantive differences in how the dispute will be dealt with, depending upon which

forum is selected. Trial by jury, examinations for discovery and defence medicals are all available once a matter is in litigation, while none of these rights exist in a proceeding before the Financial Services Commission. Additionally, FSCO arbitrators do not have equitable jurisdiction as judges do. Finally, there is a marked difference in how certain substantive and procedural issues are likely to be determined, depending upon whether the matter is adjudicated before FSCO or the Court.

Two recent cases dealing with disputed catastrophic cases demonstrate how the procedural and substantive differences outlined above can result in radically different treatments of the same issue.

In the case of *Murray and Aviva* (FSCO A07-000015)., argued before Arbitrator John Wilson, the insurer sought to have a CAT DAC reopened. In that case, the CAT DAC was favourable to the insurer's position, but the insurer wished to have a further assessment conducted before being put to the cost of a hearing on the issue, given Aviva's concern that the CAT DAC may not have been sufficiently comprehensive in its scope. Arbitrator Wilson refused the insurer's request, stating that it would not be appropriate to "reopen" the DAC once a final opinion had been rendered. He went on to add that the DAC was obviously so flawed as to render its first determination of questionable value, because psychological issues had not been identified and addressed. Given that this was the outcome in the case of positive DAC determination, it seems highly unlikely that an unfavourable DAC would be "reopened" by a FSCO arbitrator at an insurer's request. At the same time, the conclusion that the DAC was so flawed as to be useless (as suggested in the *Murray* case) would obviously not sit well with an insurer who has paid handsomely for the DAC and is now bound by its unfavourable outcome

In contrast to the ruling in *Murray* which suggest that an insurer has no way to obtain evidence to challenge a CAT DAC, in the case of *Baron v. Kingsway* (2006), 80 O.R. (3d) 290. the Court took the opposite approach in ordering contested defence medicals. In that case, the insurer was permitted to conduct medical assessments under section 105 of the *Courts of Justice Act* in respect of a contested catastrophic claim. This was after the insured person's refusal to attend similar section 42 assessments subsequent to the commencement of litigation. The insurer had discontinued attendant care benefits subsequent to the section 42 non-attendances, a remedy that the Court agreed was available under the *Schedule*. Justice Pardu made the following observations:

> *[37] A CAT DAC assessment further cannot be conclusive for all time as to an insured's entitlement to SABS, as an insurer may stop payment of benefits where an insured refuses to attend an insurer's health professional or vocational rehabilitation expert examination under s.42. Section 42(3) gives an insurer the right to schedule these examinations as often as is reasonably necessary. An insured and insurer may well disagree to the necessity and the propriety of any refusal. These disputes need resolution, again in the face of DAC assessments.*
>
> *[38] It would be artificial to conclude that an insurer could argue that attendant care needs were nominal, yet deny the ability to argue that there was no catastrophic impairment. DAC assessments may be contradictory. Here one concluded that the insured could work and the other that he was catastrophically impaired. There must be a venue to resolve these issues.*

Justice Pardu's "common sense" approach in recognizing the need to resolve conflicting assessments simply has not worked before FSCO. The availability of defence medical examinations in litigation pursuant to the *Courts of Justice Act* and the *Rules of Civil Procedure* provided a procedural means of resolving the issue that was before the Court in *Baron*. Yet the issues identified in the paragraphs of the judgment quoted above really have not been perceived as a problem to be remedied in cases before FSCO, likely in part because the *Dispute Resolution Practice Code* provides no remedy and arbitrators lack the inherent jurisdiction to order assessments.

In addition, contrary to Justice Pardu's comments at paragraph [38], above, in the recent case of *Shaughnessy and Aviva* (FSCO A06-001546)*,* Arbitrator Wilson found that an insurer could not use the procedure described by the Court of Appeal in *Fernandes* to challenge catastrophic designation *per se*, but instead could only use it to challenge entitlement to particular benefits. While acknowledging that he was bound by the Court of Appeal, the Arbitrator declared passages from that ruling to be dicta, and therefore not binding - such as the following:

> *With respect to the motion judge, in my view it was not the intent of the legislature that an insurer would be forever bound by a CAT DAC that is favourable to the insured, and that the dispute resolution mechanism is only available to an insured who wishes to dispute an unfavourable CAT DAC finding.*

The jurisdictional differences between FSCO and the Courts do not end with medical examination rights and procedure. Indeed, there is a growing body of case law indicating that, once litigation has been commenced, the *Rules of Civil Procedure* will generally take precedence over the procedures set out in the *Schedule*.

In the Court of Appeal ruling in the case of *Igbokwe v. HB Group* (2001), 55 O.R. (3d) 313 (C.A.). the effect of the settlement regulation was considered in the context of accident benefits claims that were the subject of litigation. The Court stated in that case:

> *Section 9.1 was never intended to affect Rule 49. The difficulties that would result from offers to settle under Rule 49 received on the eve of trial and during trial, particularly jury trials, do not permit s. 9.1 and Rule 49 to work in tandem. Once an action has been commenced, the relationship between claimant and insurer becomes adversarial. Offers to settle litigation fall under Rule 49 and the rule is a complete code. Section 9.1 was not designed to accord special rights or impose obligations on claimants and insurers on settling their court proceedings.*

As a result of this ruling, the settlement disclosure notice and 48 hour "cooling off' period do not apply to a case that is settled by way of a Rule 49 offer in litigation. This is a procedural difference that can translate into significant differences in the way that an accident benefits claim can be negotiated to a resolution depending upon whether the claim is before FSCO or the courts. The argument that was advanced on behalf of the insurer in *Igbokwe* may have additional ramifications that have not yet been explored in relation to the interest provisions set out in the *Schedule*. As the insurer's good faith obligations have been interpreted increasingly broadly, the likelihood of a finding that benefits are "overdue" has increased, even where the claim may now be many years old

and may never have been formally advanced by an insured person. The automatic award of interest at 2% per month, compounded, can easily surpass a generous damages or bad faith award.

FSCO has generally been very liberal in awarding interest in such cases, although there is a line of reasoning which follows the "exception" in *Attavar*, denying interest altogether where it is found that the conduct of the insured effectively precluded the insurer from identifying and responding to the claim in question. *(*See *J.C. and Progressive* FSCO P04-00036 for example).

In similar cases advanced before the courts, interest at rate set out in the *Schedule* has tended to flow automatically from a finding that benefits are overdue. To date, the majority of cases on this point have been decided without the benefit of a calculation setting out the value of the disputed interest, which if available, would surely make it harder for the court to continue to characterize such interest payments as compensatory rather than punitive. (*Black v Dominion of Canada General Insurance Co. [2007*] O.J. No. 4011; and *Mascitti v. Gore Mutual Insurance Co.)*

Recently, there have been two cases, *Heath v Economical* (28 June 2007), London Court File No. 33402 (Ont. S.C.); and *Hogan v. State Farm* [2003] O.J. No. 50, in which the court has refused interest at the *Schedule* rate, awarding the more realistically compensatory rate set out in the *Courts of Justice Act* instead. This seems an eminently sensible approach in cases where the claim may be substantively "saved" by virtue of the principles enunciated in *Smith v. Co-operators* [2002] 2 S.C.R. 129., but where the application of 2% per month of interest would indeed be punitive.

Is there still a role for FSCO?

According to the *Osborne Report: Report of Inquiry into Motor Vehicle Accident Compensation in Ontario*, the purpose of the Dispute Resolution Branch of the Financial Services Commission was to provide an expeditious and cost effective way for insured persons and insurers to resolve disputes about accident benefits.

With the original goal of ensuring that victims of motor vehicle accidents receive timely compensation at less cost through the provision of no-fault benefits, the Dispute Resolution Branch would play an important role by also ensuring that any disputes that arose between insurers and insured persons would also be resolved on a timely basis at less cost. With that said, the Government, in its ultimate wisdom did not compel all disputes to be determined at FSCO. The courts are also an option. The government decided that this choice of forum was a fundamental decision to be made by an insured person. Now that these two systems have operated side by side for eighteen years, the problems created by having two methods of dispute resolution are readily apparent. Questions need be asked and the answers evaluated.

Is applying for arbitration more cost effective than litigating? Cost of productions are likely to be close to the same. FSCO tries to limit the number of experts involved in the hearing itself. However, in preparing a case for arbitration, counsel is likely to put numerous experts and physicians under summons. The hearing is shorter at FSCO than in a trial, with most hearings lasting less than a week. While things are streamlined, an arbitrator's jurisdiction to award costs is limited by the legislation. There is a strict fee schedule for witnesses for preparation time and for reports. There is no chance

a successful Applicant at FSCO will recover 100% of expert fees, especially where there are engineering or accounting issues at play, or where multiple experts are required to address complex medical issues. Moreover, the Legal Aid tariff governs the rate of compensation for costs in an arbitration, which tariff can be adjusted, according to the *Dispute Resolution Practice Code*, to an amount up to $150 per hour for successful counsel in certain circumstances. Thus, while the ultimate costs of a proceeding may be cheaper before FSCO, the "costs" actually paid by a successful party to obtain a ruling may be higher when these factors are considered.

Is arbitrating at FSCO more expeditious than going to court? While FSCO prides itself on being able to provide hearing dates within weeks of a pre-hearing, typically, cases are arbitrated anywhere from eight to sixteen months after filing for arbitration. Practically speaking with the need to respond to various production requests and the need to accommodate counsels' schedules, the reality is that arbitrations typically cannot occur any sooner. While this is decidedly quicker than the courts in some parts of the province, it is not necessarily ultimately quicker. The reason for this is that the length of time to obtain a written decision from an arbitrator can vary greatly. While the median time of decision release is under 90 days from the time of decision, there are some arbitrators who are notorious for taking more than a year, and in some instances up to two years to generate the written decision. Where the time to get to trial has decreased significantly through such initiatives such as Case Management, Status Hearings and Simplified Procedure, it is not clear that FSCO is a significantly faster process.

What about the fact that judges and arbitrators may develop different approaches to deciding accident benefits cases? One of the principal problems with having two separate fora is that judges are not bound by the decisions of FSCO arbitrators or by the Director or his Delegate on appeal.

While judges may take judicial notice of decisions at FSCO, judges do not find themselves bound by those decisions: see for example, *Opoku v. Pal and Coseco* , (2000), 49 O.R. (3d) 97 (Ont. C.A.) *Axa v. Kitchenham* (19 August 1998), London Court File No. 23899/96 (Ont. S.C.), leave to appeal refused April 7, 1999 and *Daley v. Economical* 206 O.A.C. 33 (Ont. C.A.). This can lead to differing interpretations of the *Schedule*.

Different standards of review will also apply, depending upon whether a matter is decided through FSCO or the courts. Clearly, if a matter is initiated in the court system, the standard of review applied on appeal of a judge's decision would be correctness. If one takes an arbitration to FSCO, the standard of review applied to an arbitrator's decision by the Director or his delegate would be correctness. Given the presence of a privative clause in the *Insurance Act,* if there is a dispute with a Director's decision, judicial review by the Divisional Court is the only recourse. In the decision of the Divisional Court in *Kirkham v State Farm* [1998] O.J.No. 6549 (Div. Ct.) at para 5, the Court stated:

> While the Director's Delegate came to the correct decision as to the limitation period created by section 281(5) we feel it important to note had he reached the wrong decision, such decision would not have been protected by curial deference. The Legislature gave an injured insured the choice of pursuing a benefit claim in either the court or by arbitration under the Insurance Act. The Legislature could not have intended that the limitation provision set out

> in section 281(5) could vary dependant on where the claim was made. The court in interpreting the limitation provision is restricted to a standard of correctness. For consistency and fairness, the Ontario Insurance Commission must be bound by the same standard.

There have been some decisions which have held that if the FSCO decision goes to the heart of the jurisdiction of the arbitrator to make a decision, then correctness is the correct standard. (See *Turner v. State Farm* [2004] O.J. 731 (Div. Ct.)).

While there have been conflicting decisions over the proper standard of review from a FSCO decision, as a general proposition, due to the presence of a privative, the proper standard, up until March 7, 2008 appeared to be patent unreasonableness.

Having two fora also creates the possibility of bifurcated proceedings. An insured could bring an arbitration in FSCO and then subsequently proceed to court on the issue of punitive damages, for example. In addition, as was demonstrated in the case of *Alfred v. Allstate* (FSCO A98-000559); and 2004 CanLII 9410 (Ont. S.C.)., an insured person who is denied a benefit in one forum can attempt to have that decision effectively overruled by reframing the issues and then proceeding in the alternate forum. In such a case, it is possible that contradictory findings of fact could be made by different decision making bodies when dealing with the same facts.

Given these issues, the question that must be asked is whether or not FSCO is meeting its mandate and even if it is, whether the practical problems of having two separate systems outweighs any potential benefits.

Harmonization With Collateral Benefits

Since the introduction of OMPP, little has been done to improve the level of co-ordination between no-fault benefits and other forms of disability benefits in order to promote fair recovery, while preventing double recovery following a motor vehicle accident.

With Bill 59, "temporary disability benefits" being received prior to an accident were excluded from the calculation of pre-accident income, although they remained deductible from any amount payable as a weekly benefit. Benefits received under the *Employment Insurance Act*, meanwhile are not deductible, whether they are paid out as a result of the motor vehicle accident or not. These provisions overtly permit under and over-compensation respectively.

Pursuant to the overt wording of the *Schedule* as it relates to non-income collateral payments, the FSCO Appeal decision in *Allstate and Da Rosa* (FSCO P04-00033) interpreted the words "reasonably available" as follows:

> *...where an application has been made and refused, the [claimant] is entitled to rely on the collateral payer's rejection as proof that the benefit is neither received nor available. She is not required to pursue legal remedies against the collateral payer. The [insurer] bears the onus of proving the plaintiff is "entitled" to the collateral benefit, and cannot meet the onus if the application has been made and rejected.*

Practically speaking, this approach as it relates to the interaction between no-fault benefits and OHIP

coverage is promoting a two-tiered approach to access to health benefits. Frequently, hospitals (particularly rehabilitation hospitals) are aware that victims of motor vehicle accidents have private coverage for care and other services, and therefore advise patients that additional services are required beyond those which are funded through the hospital. This is routinely seen in the case of attendant care claims advanced for periods of time during a hospitalization.

The Divisional Court ruling in May 2008 upholding the Director's Delegate establishes that auto insurers are now usurping the role of the Ministry of Health as first payers when there has been an automobile accident.

Furthermore, it is obviously the case that, following the receipt of funding or a settlement from the no-fault carrier, an insured person can later pursue his or her remedy as against the collateral carrier and obtain double recovery by simply pursuing a certain strategy in litigating contested claims from different insurers independently.

Even where the claims are pursued in tandem, or with the full knowledge of the accident benefits carrier, it does not appear that lump sum settlements will necessary constitute collateral benefits which are deductible pursuant to the terms of the *Schedule*. In the recent judicial ruling in Cromwell v. Liberty Mutual (2008) CanLII 3409 (ON S.C.), the insured was successful in settling her long term disability claim on a lump sum basis. Although Justice Lofchik accepted that the long term disability policy was a policy of indemnity, meaning that weekly benefits payable under that policy would be deductible from accident benefits that were owing on an ongoing basis, the lump sum settlement of the LTD claim received by the insured was not, to the extent that it represented the payment of something other than defined arrears obligations.

In that case, a portion of the settlement was earmarked for "taxable" arrears. This portion of the settlement was found to be deductible, given that it was paid to satisfy past obligations to have made periodic benefits owing by the long term disability carrier. However, it was held that the nature of the balance of the lump sum did not clearly reflect "net weekly payments for loss of income... under any income continuation benefit plan" which in turn would trigger the deductibility provisions of the *Schedule*. The settlement had been achieved taking into account potential future obligations which had not yet crystalized as well as exposure for extra-contractual damages which had been claimed in the litigation. The Judge placed great significance on the fact that the ultimate settlement number reflected the maximum authority which had been extended to negotiate this claim, rather than a principled calculation of the value of "net weekly payments for loss of income."

If the reasoning applied in this case is accepted elsewhere, it clearly creates tremendous potential for double recovery in the context of a collateral benefits claim. Where entitlement is clearly demonstrated, the insured is given a strong incentive to "settle" the future long term disability claim on a significantly discounted basis rather than continue to have the benefits received but deducted from ongoing no-fault benefits. The potential for bad faith settlements on this basis should not be underestimated.

Harmonization with WSIB

The interaction between section 59 of the *Schedule* and the practices and procedures of the Workplace Safety and Insurance Board ("WSIB") and Appeals Tribunal ("WSIAT") demonstrates one area where a considerable amount of work has yet to be done in order to bring about a fair and consistent means of providing benefits to individuals who are injured in motor vehicle accidents during the course of their employment.

A straightforward reading of section 59 suggests that the drafters of the *Schedule* presumed some level of harmony between the operation of the statutory accident benefits scheme and the *Workplace Safety and Insurance Act* ("*WSIA")*, where the insured would still have access to accident benefits on an interim basis under certain circumstances where there was ambiguity as to whether or not section 59(1) applied.

Specifically, section 59(1) states that a basic exclusion applies where an insured is entitled to receive workers compensation benefits as a result of an accident. Subsection (2) creates an exception to that rule, where the insured makes an election referred to in Section 30 of the *WSIA* to bring an action, "so long as the election is not made primarily for the purpose of claiming benefits under this Regulation." Subsection (3) states that no weekly benefits are payable in respect of any period of time before the election under section 30 of the *WSIA* is made. Subsection (5) states that, if there is a dispute as to whether subsection (1) applies, "full" accident benefits are available if the insured person provides the insurer with an assignment of any benefits to which he or she may become entitled, and that assignment is approved by the administrator of WSIB.

In theory, therefore, there is a mechanism to ensure that statutory accident benefits are paid to an accident victim on at least an interim benefit, while disputes pertaining to the application of section 59(1) are resolved, with the insurer's payments being protected to the extent that there is an approved assignment from WSIB on the file.[122] In practice, however, the reality is much messier.

For starters, neither a judge nor an arbitrator has jurisdiction to determine all issues that would arise in a dispute concerning the applicability of section 59 of the *Schedule*, given the exclusive jurisdiction of WSIAT to determine whether WSIB benefits are available to an insured, and whether section 28 of the *WSIA* eliminates the right to sue, and therefore means there can be no "bona fide" election to claim damages under section 30 of the *Act*. A judge or arbitrator would have jurisdiction however to determine whether an election was "bona fide" for other reasons, for example, if there was a question as to whether damages could be claimed based upon an unfavourable liability situation.

Therefore, FSCO arbitrators faced with disputes pursuant to section 59 of the *Schedule* have adopted the position that insurers wishing to defend a claim under section 59(1) of the *Schedule* must actively pursue an application pursuant to section 31 of the *WSIA*, seeking an order to the effect that the insured is entitled to WSIB and/or the insured's civil rights are extinguished as a result of the operation of section 28 of the *WSIA*. If the "bona fides" of an election are questioned on other grounds, FSCO retains jurisdiction. If there are alternative grounds upon which the "bona fides" of an election may be questioned (i.e., relating to tort liability and/or the operation of section 28 of

WSIA), no one forum can deal with all issues that may arise pursuant to section 59(2) of the *Schedule*. The impracticalities of this situation are numerous.

While WSIAT has exclusive jurisdiction to address the question of whether tort rights (and therefore accident benefits entitlement) has been extinguished by operation of the *WSIA*, the process for obtaining such a determination is far from satisfactory from an insurer's point of view. There is presently mixed authority before the *WSIAT* as to whether a statutory accident benefits carrier acting alone even has standing before the Tribunal to bring a section 31 application (*WSIAT Decision No.* 14/06, dated February 12, 2007 and *WSIAT Decision No.* 2035/05, dated January 20, 2006), given that the language of that section refers to the right of an accident benefits carrier to seek a determination as to whether "the plaintiff is entitled to claim benefits under the insurance plan." Where there is no civil suit (yet), there can be no "plaintiff" unless that word is interpreted to include a claimant in the accident benefits context, as has been more recently interpreted (*WSIAT Decision No.* 1362/06I, dated October 10, 2006). However, as none of these rulings are binding upon subsequent decision makers, there remains a degree of uncertainty in the law on this rather crucial point.

If it is necessary for there to be a "plaintiff" before an accident benefits carrier can seek an order pursuant to 31 of the *WSIA*, it would be necessary to wait until a civil action has been commenced before even launching a proceeding before WSIAT, meaning that it may not be possible to even get started in determining whether section 59(1) will apply until up to two years have elapsed following the accident.

Even if the WSIAT continues to move away from this analysis, as would presently appear to be the case, there are still practical reasons why a section 31 application should proceed, where possible, in tandem with a civil action. There are of course no discoveries in proceedings before the WSIAT, and the Tribunal considers its role to be one of fact finding rather than dispute resolution *per se*.

Thus, the rules of evidence are extremely relaxed, and it is entirely possible that, in the absence of discoveries, the insurer may have no idea of what evidence will be presented by other parties, or how credible the witnesses will be in advance of the hearing. Therefore, it is often strategically helpful to have conducted discoveries in the tort proceeding before the section 31 Application takes place. This consideration along with the extremely slow moving nature of proceedings before the WSIAT means that an insurer may have to wait for years for a determination under section 31 of the *WSIA*, by which time there may no longer be an active accident benefits claim, although a significant amount of money may have previously been expended.

There is also no mechanism for the recovery of legal costs associated with a section 31 Application by either party. This is obviously a highly significant factor in the handling of modest exposures in the accident benefits context.

More startling, once an insurer has successfully argued a section 31 Application, and obtained an order confirming that the insured was in the course of his or her own employment at the time of the loss and has no civil right to sue due to the operation of the *WSIA*, there would appear to be absolutely no reliable way to collect on an approved assignment, where the insured does not

thereafter reapply for benefits with Workers Compensation. In the case of serious ongoing injuries, it is obviously in the insured person's interest to apply to WSIB for benefits given the unavailability of recovery elsewhere in this scenario. However, in the case of more modest injuries which have since resolved, or in the case of an insured who has left the jurisdiction, there may be no motivation to reapply for WSIB, and the practical reality is that the WSIB adjudicators are inconsistent in their approach to reimbursing accident benefits insurers in these circumstances.

Indeed, the longer it takes for a WSIAT determination, the more prejudicial it is to the accident benefit insurer, in that recovery may not be available on the assignment from the WSIB if no WSIB claim is pursued by the claimant. Even if a claim is registered with the WSIB, the level of recovery by the accident benefits carrier on the assignment is wholly determined by the WSIB, based on a retrospective, critical analysis of what should or should not have been paid using WSIB criteria and rates of payment, and without regard to the procedural and substantive entitlements that may exist under the *Schedule.*

This apparent "gap" between the operation of section 59 of the *Schedule* and the WSIB scheme was the subject of a recent WSIAT decision.(see *WSIAT Decision No. 983/07*, dated June 26, 2007.) The insurer in that case had an approved assignment and had been successful on a section 31 Application. The insured person did not thereafter apply for WSIB benefits, and the WSIB adjudicator refused reimbursement pursuant to the approved assignment on the grounds that there was nothing for WSIB to pay since there was no claim by the injured worker. The insurer sought to appeal this determination before the Appeals Branch, which found that the insurer had no standing to bring an Appeal on this issue, as the only access that an automobile insurer would have to a remedy under the *Act* is as specifically set out at Section 31.

The Appeals Branch decision was upheld by the Tribunal, with the Vice-Chair noting that:

> While this is not an issue before me, it appears that further proceedings may be possible based on the contract prepared by the Workplace Safety & Insurance Board and executed by the appellant insurer and insured worker. It appears from the judgment in the **Richer** case that the Court of Appeal has treated similar issues as a matter appropriately addressed by the Court.

In other words, it is suggested that an automobile insurer may have a remedy against either the insured person or the WSIB, enforceable through court proceedings. However, if the insured person never agrees (as a term of the assignment) to apply for WSIB benefits, and the WSIB therefore "owes" the injured worker nothing, it is difficult to see how the Court would address this situation.

In such cases, what we seem to be left with in practical terms is a failure on the part of the insured who receives "interim" benefits under the *Schedule* and thereafter fails to act in good faith towards his or her own insurer. In this case, there is no particular mechanism to protect the insurer for the payments previously made pursuant to section 59(5) of the *Schedule.*

In insisting that this is the procedure to be followed by insurers who question the bona fides of a tort

election, it is important for judges and FSCO arbitrators to be mindful of how very impractical this process is. Even though WSIAT clearly has exclusive jurisdiction to determine whether an insured's civil rights have been extinguished by operation of the *Workplace Safety and Insurance Act*, judges and FSCO Arbitrators still have jurisdiction to determine whether an election appears to have been made "primarily for the purpose of claiming" accident benefits, and they should be willing to apply this jurisdiction. Additionally, it is clear that greater harmony between the no fault scheme and workplace safety insurance will have to be achieved with future legislative developments.

The ultimate outcome in WSIAT case No. 983/07 creates a strong disincentive for insurers to make interim accident benefits payments when there is a probability that section 59(1) applies to the situation and section 59(2) does not. The costs associated with pursuing reimbursement from WSIB, along with the uncertainty that any amount will ever be recovered make the situation unworkable. The potential risk of an occasional adverse outcome may actually be more palatable for insurers in certain instances, than simply paying out unrecoverable benefits on an indefinite basis for marginal or questionable claims.

At the same time, it has been our experience that there is quite widespread confusion (including among some FSCO Arbitrators) regarding the procedure that should be followed in administering such claims withing the SABS context. To the extent that the procedure is being clarified through FSCO jurisprudence (see for example *Lin and Liu and ING, FSCO A06-001689*), it is evident that "proper" handling of claims under section 59 of the *Schedule* is a complex matter. There would seem to be an extremely high burden on the insurer to lead the insured person through the process through the provision of detailed disclosure essentially amounting to legal advice, sufficient to allow the insured person to understand his or her rights and responsibilities under both the *Schedule* and the *Workplace Safety and Insurance Act*.

Priority Rules

The promulgation of the priority regulation came out of the blue to all counsel acting in the area. One of the authors of this submission vividly recalls attending a meeting on a Friday afternoon with most of the active counsel in this field, along with senior representatives of FSCO, where the issue was not raised and not known to any of the participants, including the Director of Arbitrations. The regulation was gazetted on either that day, the prior day or subsequent business day. It was learned thereafter that this regulation was lobbied for by insurers, at a high level, without specific involvement of any of the claims handlers or claims managers.

Unfortunately, where consultation on the initial product was denied to any of the ground level users, problems arose and continue to arise with regularity. The *Allstate and Brown* (FSCO A97-000579) and *Vieira and Royal and Chubb* (FSCO P04-00016) decisions from the Financial Services Commission highlight the problem of insurers attempting to subvert their obligations to an injured person pursuant to the priority regulation by refusing benefits on the grounds that there is no underlying policy of insurance. While these cases speak clearly to this practice, it still persists and may even be on the upswing.

Unfortunately, representatives of applicants continue to send applications for accident benefits to

multiple insurers, especially where they may have received a negative reply from the first insurer to whom an application was made. Where a second insurer receives an application and responds to it, without even being aware that the first application was submitted elsewhere, the second insurer has no recourse against the first insurer who was non-compliant with the priority regulation.

Insurers, including the Motor Vehicle Accident Claims Fund (MVACF), not only deflect applications, but they also fail to accept proper priority claims presented by other insurers who may have received a first application, but have no contractual or statutory obligation to the insured. The priority regulation obliges the first insurer to whom an application is submitted to adjust the file and thereafter put other insurers on notice. Where a "first" insurer honours its obligation under the regulation, there is often no speedy, efficient or in some occasions, courteous, response received from the second insurer (if a response is ever sent at all).

Furthermore, the 90 day notice period in which a first insurer must notify any others against whom priority is asserted simply does not work. The decision maker has a great deal of discretion in deciding whether 90 days was a "reasonable" time frame in which to conduct a priority investigation. The interpretation of the 90 day notice period set out in the priority regulation has gone to the Ontario Court of Appeal in the case of *Kingsway General v. West Wawanosh*. In this case West Wawanosh did not send a letter to Kingsway within 90 days of its receipt of the application for benefits, but did have a copy of the letter sent by the claimant's counsel to Kingsway doing that exact same thing. Kingsway had actually opened a file and done investigations but decided to close its file within the initial 90 days, all of which was known to West Wawanosh. In addition, West Wawanosh started the arbitration within a year of the accident and certainly less than one year from the date of the notice given by the claimant. Nonetheless, the Court of Appeal, in upholding the decision of the Superior Court overturning the private Arbitrator's decision, stated that, even where the second insurer had actual notice within the 90 days but that notice was not provided by the first insurer directly, the 90 day notice period had *still* been missed. To add further insult to this initial injury, the second insurer acknowledged that it was at priority to respond to the claim but for the "limitation" (i.e. the "notice") argument. This claim, involving a catastrophic injury, ultimately had a value well in excess of $1 million.

The impracticality of the notice period as it has been interpreted, is highlighted in a multiple insurer scenario. In the Superior Court ruling of *Pilot v. Royal and SunAlliance* (2006), 80 O.R. (3d) 308, the first insurer had put a second insurer on notice within the 90 day notice period. The second insurer, armed with additional information about the policy holder sufficient to assert priority disputes against other insurers, then put third and fourth insurers on notice, but outside the 90 day notice period. However, it will often be the case that a "first" insurer will have access to only limited information when a claim is received, particularly if it has no contractual relationship with the insured. If it correctly identifies another potential insurer within the 90 day notice period but not the "correct" insurer, the 90 day notice period will nonetheless leave the first insurer with priority.

Limitation periods in the Province of Ontario have been streamlined under the *Limitations Act, 2002*. Notice periods have been reduced or eliminated. As such, the priority regulation is an aberration in the Province of Ontario relative to the stated intention of the legislature to create certainty in terms of limitations, as well as a reasonable uniform limitation for actions. Notice periods are not supposed

to be limitations. They are supposed to be notice periods. A decision maker should have the discretionary jurisdiction to provide relief from a notice provision, so long as the ultimate limitation is met. That is how notice periods operate in other areas of the law. Accordingly, the 90 day notice period cannot be viewed as a limitation period and must be relaxed if not eliminated in order to create additional fairness within the system.

Judges in priority disputes have shown some degree of ambivalence in addressing priority disputes. Notwithstanding the practical difficulties of complying with the 90 day notice period, insurers are presumed to be sophisticated and therefore not well positioned to seek relief when the notice period is missed. It is further presumed that the uniform strict interpretation of the notice period will result in the contested priority cases "evening out" between insurers in the long run. Anecdotally, this does not seem to be the case. Insurers perceived to be generous to deal with get a disproportionate number of claims submitted to them at first instance and conversely, insurers that are perceived as difficult to deal with get well under their rightful share of claims (or will successfully deflect those which they do receive). The effect of the current state of the law, is to penalize the more responsible insurers and to reward those less responsible.

The other pragmatic problem that arises in all of these priority disputes relates to the potential of an inherited bad faith claim when priority is later assumed. An insurer that may receive the first completed application for benefits may be 100% certain that it is not ultimately responsible for paying the claim. It may commence the priority dispute as against another insurer, and yet pay less attention to the claim thereafter, with the understanding that ultimately another insurer is going to assume carriage of the file. An insurer assuming such a file will be taking over a soured relationship with its insured, as well as the potential for involvement in bad faith litigation on the basis of the other insurer's prior handling.

The majority of the priority disputes we see relate to whether a claimant falls within the definition of dependency found in the *Statutory Accident Benefits Schedule*. Dependency investigations are intrusive and protracted. The investigations begin with initial inquiries and statements at the adjuster level and are then followed by production of financial records and personal information.

Once private arbitrations are commenced there are usually examinations under oath, often followed by repeat testimony at the arbitration hearing itself. In fact, these detailed factual investigations are not dissimilar to the intense scrutiny of financial affairs upon marital separation in the family law context. However, unlike in the family law context, the people to whom these inquiries are addressed are not usually litigants. Financial and personal information will be sought from common law spouses, former spouses, married children, grandparents and occasionally foster parents and other people acting in *loco parentis* to a claimant. An accident involving a family member is traumatic enough. To then require a family to completely reveal its financial situation and personal relationships to protect the insurer's interests simply exacerbates an already difficult situation.

In addition to the stress, delays and costs associated with the financial investigations, once the relevant materials are assembled, they remain difficult to interpret, given the competing lines of cases interpreting what it means to be "principally financially dependent". The arbitral authorities from the Financial Services Commission as applied by a number of private arbitration decisions say

that the receipt of 50 plus 1% of one's financial support from another party is enough to create a relationship of principal financial dependence. The private arbitration decisions of *Federation v. Liberty Mutual* and *Co-operators v Halifax* (May 7, 1999, Arbitrator Samis), online: www.ztgh.com/PrivateArbDecisions (December 14, 2001, Arbitrator Samis), online: www.ztgh.com/PrivateArbDecisions which were upheld on appeal, state that a finding of 50 plus 1% financial dependence does not end the inquiry. Instead, following the Ontario Court of Appeal decision in *July v. Neal* (1986), 57 O.R. (2d) 129 (Ont. C.A.), the proper inquiry is whether the person, on an objective basis, could be financially independent.

All of this is a lengthy preamble to the ultimate conclusion that disputes over dependency are long, protracted, inexact, complex, expensive, troublesome and invasive to the family of claimants and simply inefficient.

From an underwriting perspective, the uncertainty around what constitutes a dependant means that insurers cannot predict how many dependants an individual might have for the purposes of charging premiums and may be saddled with paying what are often significant accident benefits claims to someone who could not easily have been identified in advance as a potential "insured".

One of the other problems faced by the litigants to these priority disputes relates to the mandatory use of private arbitrators. Whereas disputes of the Financial Services Commission of this nature tended to work their way through the system in between six to twelve months, private arbitrations are typically taking in excess of two years and as many as four years to get to a decision.

In order for an arbitrator to be selected by the parties, he or she must generally be recognized as having some expertise and understanding of this area of law. Many of these arbitrators also remain in private practice in this area and consider litigants before them as professional colleagues. Others are mediators working as arbitrators as well, and are reliant upon these litigants as sources of referrals to their active mediation practices. Thus, it is suggested that private arbitrators are disinclined from forcing litigants to move matters ahead at the pace that would be forced upon litigants should these same disputes be before the Financial Service Commission of Ontario or even the courts.

In trying to arrange private arbitrations for our clients, we are finding the many of the most experienced private arbitrators no longer want to do this kind of work. Anecdotally, they report that the number of pre-arbitration hearings required to deal with arranging of examinations under oath, exchange of productions and other administrative responsibilities are a major loss of time. Moreover, last minute settlements and adjournments result in an unacceptable number of "lost days" and, therefore, lost revenues.

It is not clear whether the existing priority scheme is salvageable. At the very least, some wholesale changes are called for. It is necessary to further clarify what does and does not constitute a completed application for accident benefits. It is appropriate for a certification process to occur where this dispute is between insurers as to who may have received the first application.

It is necessary to prohibit applicants from applying to more than one insurer for the same accident.

Whether the application is made simultaneously as against multiple insurers using a "scatter gun" approach, or whether an applicant applies to one insurer, waits some time and receives no response, or receives some negative feedback respecting that application and decides to apply elsewhere, problems arise when multiple applications are sent. Insured persons must be discouraged from applying to more than one insurer for benefits. If they have applied to the wrong one, it is up to the insurer to whom the application was sent to ensure that the appropriate insurer is put on notice.

There also needs to be some greater accountability against second insurers to whom a notice of priority is sent, including MVACF, in responding to priority disputes. An insurer to whom a priority dispute has been addressed should be given 30 days within which to respond to the priority notice outlining their position as to why they will or will not accept priority or what additional information may be required before they can make that determination. An insurer that fails to provide that response will have their failure to respond taken into account by the decision maker when costs are addressed in the priority dispute.

In terms of possible changes, the 90 day time limit should be eradicated altogether, or at the very least watered down to make clear that it is intended to be a notice period from which relief can be granted by any decision maker, including an arbitrator under the *Arbitration Act*.

A distinction must be drawn between priority disputes and loss transfer disputes. Priority disputes can lead to a situation where an insurer has received a claim that it is ultimately not responsible for at all. This is to be distinguished from the claim which an insurer might have a subrogation right against another insurer by virtue of the loss transfer provisions. As a result, any insurer (not just MVACF) that receives an application that is not ultimately theirs by virtue of a priority dispute should have the ability to recover all of its costs associated with that claim. Any insurer should be able to recover reimbursement for adjusters, legal and interest fees in addition to the accident benefits payments from the another insurer. By making such a change, insurers would not have incentive to routinely deny priority as a cost saving method. It may also result in greater accountability and responsiveness by insurers in priority disputes.

It is also wholly inappropriate for that second insurer to inherit a bad faith or special award exposure from a first insurer for its inadequacies in file handling. Thus, a specific regulatory change would be appropriate to ensure that insurers accepting priority from other insurers are not exposed to bad faith or special award claims for the actions of the first insurer while continuing to hold the first insurer accountable for that bad faith or special award exposure as a stand alone claim. Thus, insurers would not be relieved from their responsibility of good faith handling. More importantly, insurers that are trying to act responsibly in assuming carriage of claims would not hesitate to do so where there is concern about inappropriate file handling prior to its assumption of the file's carriage.

In terms of the high volume of dependency disputes, there is a simple solution. To ensure greater certainty, expedite the process, save time and money and reduce frustrations of all parties to these disputes, reverting back to the old way of determining dependency based upon whether someone lives in a household or not, would be the simplest approach. If an individual lives with their parents and is 18 years or younger, the individual is a dependant. If the individual is over 18 but still attending school on a full time basis, the individual is a dependant. If he or she has left school but

continues to live at home, then perhaps the financial dependency test could remain. Such an approach will end the vast majority of disputes we have over which parent's policy has to respond to a young child's catastrophic injury claim where the child lives with one parent and yet there may be a basis to assert dependency claims against both parents, and possible step parents as well.

Where arbitrators at the Financial Services Commission of Ontario are well equipped to deal with these issues, have dealt with them in the past, and continue to deal with many of them in the context of disputes between claimants and insurers, there is no good reason why these disputes could not be put back within the jurisdiction of the Financial Services Commission with modest amendments to the *Dispute Resolution Practice Code* and the *Insurance Act* to provide jurisdiction to the arbitrator to deal with these matters. If each insurer were charged the same assessment fee as is charged for disputes with claimants, insurers would come out ahead, given that the minimum fee charged by arbitrators in these private arbitration disputes is usually in the range of $2,000.00 to $3,000.00, and on a full hearing, can be upwards of $10,000.00, when one factors in days of hearing, and days of decision writing, at hourly rates of between $300.00 and $450.00 per hour. As an alternative, putting these matters back before judges at first instances, on trials of an issue would be an appropriate alternative to private arbitration.

BROAD STROKES: HOW TO CHANGE THE SYSTEM

Common sense and practicality must take a more central role in this system. Procedures must be streamlined. The government must decide what is to be expected of insurers, realistically. It must create a system that is practically useable by the motoring public. Insurers must be put in a position to respond to claims of indemnity, in a fair and transparent manner.

The extent of an insurer's obligation to anticipate claims pro-actively must be clarified, and a parallel ability to gather necessary information must be extended. Specifically, if insurers are expected to anticipate all possible claims and are responsible at the end of the day for whether such claims are advanced and paid, then they must have unfettered assessment rights. If the insured person is to be treated as autonomous and capable of advancing claims once provided with a copy of the *Schedule*, with or without counsel (but one would hope that with counsel for certain) then it would be more reasonable to limit insurer assessment rights to benefits being "claimed".

Either way, a standard package of "information" needs to be developed which will serve as sufficient to meet the "duty to inform". If the insurer's duty to inform is clear to adjudicators on a case by case basis (as would seem to be the case), it should not be difficult to reduce the content of that duty to a standard code of practice and disclosure to be used uniformly. Unfortunately, to date, the cases emphasize what does not meet the insurer's duty to inform,(see *Navage v. Pilot),* but have yet to define it in positive terms.

It is also important that the procedural provisions of the *Schedule* as relating to an insured person's obligation need to be treated seriously. These provisions were included in the regulation for the purpose of facilitating the claims process between the parties. If these provisions are ignored, the system becomes more difficult to use for everyone. Costs mount. Reasonable people advancing reasonable claims end up caught in the crossfire and insurers and consumers lose at the end of the day.

The government has not been particularly transparent in its approach to the field of accident benefits in the past 18 years either. Clearly, there have been a number of shifts from the public purse to the pockets of insurers in that time frame. Many of those shifts can be said to be at the root of the current problems in the system.

It would be interesting to count the number of cases, prior to 1990, where the medical and rehabilitation limits of $25,000 over 4 years was ever exhausted. Suffice it to say, it was not common. When the medical and rehabilitation benefit limits in the no fault system climbed to $500,000 over 10 years under OMPP, and then $1,000,000 for life on Bill 164, with no real limits placed on the amounts to be charged by treatment providers, the horses were let out of the barn.

After six years of unfettered billing, the burgeoning health care industry was decidedly unhappy with the notion of capping fees under Bill 59. Those horses would not go back to the barn. Yet those capped fees, now 12 years old and largely unadjusted, are still substantially higher than anything the WSIB allows to be charged for services to their injured workers, or what OHIP permits to be charged for insured services by some of these health disciplines.

People, quite rightly, decry two tier medicine in the province of Ontario. Yet, with no fault insurance, that is exactly what we have. If a person is injured in a diving accident, he or she can stay in hospital for rehabilitation, and no hospital administrator will threaten to throw that spinal cord injured person onto the street. If, however, it is a motor vehicle accident, the hospital is quick to discharge the individual, or seek co-payment from the auto insurer. If someone needs an MRI after falling on their slippery basement floor, he or she can wait months. If the individual is in a car accident, their health practitioner fills out a certificate and submits it to the automobile insurer. One would hope that the drafters of the legislation did not intend this result, and yet, it greatly benefits the government, in that the additional costs to insurers have a commensurate savings to OHIP.

The fact also remains that when there is more money to be had in the system, there are that many more people who will devote their energies to obtaining such money. It cannot be denied that inflated or fraudulent claims continue to be advanced. The system becomes overburdened when decision makers cease to be realistic in their awards, creating more and more opportunities for claims to be advanced out of all proportion to the expenses that would actually be incurred for reasonable and necessary services if those services were being funded by the claimant rather than the first party insurer.

The adage "bad facts make bad law" can best be exemplified by a review of Ontario accident benefit cases. It is bizarre to imagine that a form, created by the Commissioner of Insurance under authority granted by the *Insurance Act* and used industry wide, can be viewed to be inadequate in setting out the rights of an insured person to commence a proceeding where that insured person was represented by legal counsel throughout. Yet, this is precisely what the Supreme Court of Canada held in *Smith v. Co-operators.*

The *Smith* decision is the springboard for the entire area of law dealing with the duty of insurer to inform its insureds following a consumer protection model. Consumer protection is laudable. However, the context in which this consumer protection exists is riddled with complex, unwieldy overly demanding and unfair regulatory provisions. This concept of consumer rights properly exists where the consumer otherwise has choices and decisions to make that differ from one transaction to another. Here, insurers are providing what is a uniform product, created by the government, and provided on a mandatory coverage basis. Taking *Smith* to its natural conclusion, there is no role for lawyers in the delivery of accident benefits. If an insured has counsel who fails to take appropriate steps in advancing claims, the consumer protection aspect of the no-fault scheme is deemed to rescue any "lost" claims, along with costs, interest and sometimes a special award or damages for bad faith.

To take this logic one step further, if nothing that the representative can do will adversely affect the insured's position, it is unclear on what basis a legal representative can claim to act on the insured person's behalf, or claim legal fees for doing so.

Based upon the outcome in certain recent cases, it would actually appear that an insured person who does not have pressing out of pocket expenditures should never advance claims in a timely fashion. The interest rate available in respect of "overdue" claims is simply too lucrative to justify the timely prosecution of claims from an economic standpoint.

Life would be a lot easier in this area if there were not two separate places to shop for justice. Where one of those two places, FSCO, has decision makers with limited jurisdiction relative to judges, in an area of law so rife with complexities requiring common sense solutions, problems have arisen.

Arbitrators cannot order interest at the *Courts of Justice Act* rate in appropriate circumstances, but judges can. Arbitrators cannot find that while a benefit is not due, the reason it is not due results from improper handling by the insurer, and as such damages flow from that breach.

All of this has led to a limbo around some provisions of the *Schedule* and rigid adherence to it at other times. Neither of these approaches make sense. Neither does it make sense to have these accident benefit issues decided in the vacuum of FSCO where tort and collateral benefits cases which deal directly with accident benefits exposures are being dealt with discreetly in court on a concurrent basis. The system as it now stands, does not do justice to the parties. Without broadening the jurisdiction of arbitrators to be more judge like in their approach, and forcing LTD claims and tort claims where there is an interface between tort and accident benefits into FSCO, the system would be far better off reverting back to the courts entirely, and doing away with FSCO.

Accident benefit entitlements should be clear and simple and easily understood by broad range of people. Right now, practising in this field is more complex and unpredictable than ever before. The law of general application as it relates to insurance contracts and first party contracts in particular should govern. Accident benefit issues should have been dealt with largely by now. If we are still dealing with this level of uncertainty almost 18 years later, there's something wrong.

As a practitioner on the forefront of this area of law for the past 21 years, I have a larger sense of frustration than many. I have devoted my career to assisting parties wind their way through the system. It has become more and more complex, and with that complexity has come greater uncertainty as to how decision makers will act. Insurers will say that they do not care what the product looks like; tell them what the product is, they will cost it, and charge the appropriate premium for it. Unfortunately, the product is so unwieldy that whatever costing is given by an insurer is so far removed from what decision makers are doing, that there is constant unhappiness. Consumers do not like products they cannot understand. Insurers spend considerable sums training staff on legislation that changes regularly, and the training on the product ends up not looking anything like what decision makers are interpreting the product to be. There has to be a way to simplify things and provide consumers a readily understood product which insurers can also predict the cost of when setting premiums.

I would be pleased to be of greater assistance to the government as it undertakes this five year review. I hope that from the above comments, you will see that I have many ideas, and I would like to think, sufficient experience to be of assistance in effecting positive change. To the extent I can be of further assistance, please do not hesitate to contact me.

Yours very truly

Eric K. Grossman