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VIA EMAIL

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RE: Ontario Automobile Insurance Dispute Resolution System Review Submissions

BACKGROUND

I am a Certified Specialist in Civil Litigation who has practiced in the field of accident benefits for most of my 25 year career, almost exclusively acting for insurers. I lead the accident benefit practice group in our firm of 46 lawyers, and our firm is likely in the top segment of users of FSCO dispute resolution services as defence counsel over its 16 year history.

I am a past Chair of the Bar Dispute Resolution Group, an organization comprised of active practitioners on both sides of the fence, who meet regularly with FSCO DR staff with a view to enhancing and improving the provision of dispute resolution services at FSCO. It was during my chairmanship of this organization more than a decade ago, that the DR Group at FSCO was honoured with a Trillium Award for Excellence in its unique partnership with the Bar in enhancing its approach to delivery of dispute resolution services.

Despite my numerous affiliations, the below submissions are being provided personally, and do not necessarily reflect the views of any of mine or my firm's clients, or any of the numerous organizations or committees I am affiliated with. I must give credit to my partner Jennifer Griffiths and my associate Christine McKenna, whose written work and past published materials I have borrowed liberally from in creating these submissions.[1]

[1] See Jennifer Griffiths, Eric K Grossman and Christine McKenna, "Accident Benefits: Lessons from the Past with the Hope for a Better Insurance Product in the Future" in *Law Society of Upper Canada Special Lectures 2008, Personal Injury Law* (Toronto: Irwin Law, 2009); Jennifer Griffiths, "Determining Catastrophic Impairment: Pastore v. Aviva Canada Inc" (2013) 40 Advocates Q 519.

The views I provide herein from an active defence practitioner's perspective will hopefully be useful in your analysis of the issues you are confronting.

THE PROBLEMS WITH DISPUTE RESOLUTION AT FSCO

MEDIATION

Martin Teplitsky, a very early advocate of alternate dispute resolution, identified that making mediation mandatory takes much of the benefit of the process and removes it: counsel are less likely to settle a case on their own, when they know that there is a mandatory process later.[2] I believe this can be said for mediation as a mandatory step in *every* case at FSCO.

There are countless problems with mediation as currently constituted. I do not intend to address all of them, but will highlight and address a few of significance.

Firstly, there is the practical reality that FSCO has turned into a collection agency for third party service providers. Treatment and assessment facilities, many of whom are abusers of the system, use the $500 mediation filing fee (and later, the $3,000 arbitration filing fee) levied against insurers as a means by which to extort nuisance settlements on their unpaid accounts; accounts which often have dubious correlation to the treatment and rehabilitation of an injured claimant. Often times, the injured person knows nothing about the unpaid bills for which mediation is pursued, and wants nothing to do with the dispute resolution process. Where the injured person has signed various documents at the clinic, invariably without legal advice or proper disclosure of what the documents set out, they learn that they will be held personally liable for any shortfall from the insurer unless they co-operate in the DR process. They are also being asked to sign applications for mediation (and arbitration) in blank or have their signatures electronically scanned and attached to the DR documents.

The second significant issue respecting mediation is that every dispute requires the same process. One can have a single dispute over a denied long handled scrubber for $10 or a multifaceted dispute over whether one is catastrophically impaired and entitled to $6,000 a month of attendant care benefits, and the process for mediation is identical in both cases. That makes little sense. Big disputes justify timely and fulsome mediation, whereas minute issues do not.

Jurisdictional Issues at Mediation

Mediators have no statutory powers of decision making. Administrators involved in processing mediation applications have even less. Yet, various critical jurisdictional issues confront the Mediation Unit regularly, and the default process is to note the jurisdictional issue as a "preliminary issue" to be addressed in subsequent proceedings, be they in court or arbitration.

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[2] See Janice Mucalov, "Mediation, like it or not" *Canadian Bar Association National Magazine* (January/February 2003), online: Canadian Bar Association <http://www.cba.org/cba/national/janfeb03/feature2.aspx>.

Jurisdictional issues covered by this problem include the claimant's failure to even apply for a benefit (where there has been no denial), the claimant's failure to attend an insurer's examination, the claimant's application being addressed to the wrong insurer, the claimant's application after he or she has fully and finally settled their claim, a missed limitation, the issue has previously been mediatied, and a claim for items not available under the *Statutory Accident Benefits Schedule* (the "*Schedule*"; "*SABS*").[3] A review of the statistics kept by the DR unit show that not a single failed attendance at an insurer examination led to a closure due to jurisdictional issues in the last three years; this is just one example of the problem. The costs associated with this deferral of jurisdictional issue approach are significant.

I will not take credit for the proposed solution to this significant and ongoing problem. The late David Braund was a senior arbitrator at FSCO, who advocated a "mini arbitration" system within mediation. This was long before the province adopted a Simplified Procedure in Superior Court. Unfortunately, he died suddenly before being able to implement this process, more than a decade ago**.**

MEDIATION RECOMMENDATIONS:

> **1. The dispute resolution system at FSCO is intended to address the issues of the injured person, and only the injured person. The use and abuse of DR at FSCO by third parties must be stopped. Disputes over third party accounts to the exclusion of all other issues, should not be permitted to be mediated, or arbitrated at FSCO.**
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> **2. Mediation respecting individual issues or items, or a combination of items, with a cumulative value of less than $3,000 should not require a formal mediation session, and should have a deemed failure process after a finite waiting period after filing, during which time the parties are encouraged to resolve the issues on their own. No mediation filing fee should be levied for such deemed failures.**
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> **3. Create a simplified summary hearing process, likely involving written submissions and possibly affidavit evidence, and no longer than a half day of hearing time, to obtain a final disposition of jurisdictional issues at the outset, before mediation applications are processed. The determination would be final and binding.**

If the above recommendations were to be implemented, it is anticipated that the strains on the administration of the system would forever dissipate.

[3] *Statutory Accident Benefits Schedule—Effective September 1, 2010*, O Reg 34/10.

ARBITRATION: Is there still a role for FSCO?

Choice of Forum

According to the Honourable Coulter Osborne's *Report of Inquiry into Motor Vehicle Accident Compensation in Ontario*,[4] 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.[5]

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 twenty three 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, but certainly not all 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.[6] 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.

Ultimately, one must question whether the limited costs awards at FSCO are dissuading claimants from choosing that forum for disputes. The answer seems to be a resounding no. Where all personal injury counsel and all paralegals act on contingency retainers, the amount of fees awarded to a successful party seems to be a less relevant consideration than ever before. To

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[4] Ontario, *Report of Inquiry into Motor Vehicle Accident Compensation in Ontario: summary of findings and recommendations* by Coulter A Osborne, Commissioner (Toronto: Ontario Ministry of the Attorney General, 1988).
[5] *Ibid* at 611.
[6] Financial Services Commission of Ontario, *Dispute Resolution Practice Code*, 4th ed (updated August 2011), r 78, online: Financial Services Commission of Ontario < http://www.fsco.gov.on.ca/en/drs/DRP-Code/Documents/DRPC-Fourth-Edition-Collected.pdf> [DRPC].

be blunt, it would appear that most plaintiff personal injury counsel prefer FSCO as their forum of choice, because they perceive that an arbitrator is far more likely to award higher damages than a judge, from which they will extract their percentage of recovery. Indeed, the decision seems to be an easy one, even where there is a concurrent piece of litigation for the tort claim, obliging counsel to fight cases on two different fronts simultaneously. Thus, the disparate results must lean so heavily in favour of FSCO as the preferred forum for injured persons, that the lower fee tariff, the lower disbursement recovery and the added cost of having two separate proceedings happening concurrently are obviously offset by the potential for greater recovery at FSCO.

Is arbitrating at FSCO more expeditious than going to court? While FSCO once prided 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. With the recently cured mediation backlog now finding its way into arbitration, it is clear that FSCO will be the slower forum for the foreseeable future.

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*,[7] and *Daley v Economical Mutual Insurance Co*.[9] This can lead to differing interpretations of the *Schedule*.

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 and Allstate Insurance Co*,[10] 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.

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[7] (1999), 49 OR (3d) 100, 100 OTC 1 (Sup Ct), aff'd (2000), 49 OR (3d) 97, 132 OAC 169 (CA).

[9] [2004] OTC 1179, 20 CCLI (4th) (Sup Ct), rev'd (2005), 206 OAC 33, 31 CCLI (4th) 27 (CA).

[10] (June 1, 1999), FSCO A98-000559; *Alfred v Allstate Insurance Co* (2004), 128 ACWS (3d) 997 (Ont Sup Ct).

The choice of fora being left to the claimant is leaving a widening gap in adjudicating claims advanced pursuant to the *SABS* 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 *SABS* procedural requirements have been followed to the letter, insurers still face vulnerability to a special award where an adjudicator may determine that the adjudication of a claim, as supported by the available evidence at the time, was wrong.[11]

Arbitration Filing Fees

A little known fact about DR at FSCO is that it is an industry funded process. It should be noted and acknowledged that politically, for economic reasons, the government will want to keep as much DR within FSCO given this economic reality, rather than put cases into court, which is not a fully user funded process. With that said, the cost to the users, both directly and indirectly needs to be examined to see if the FSCO self funded process continues to work.

At an early juncture of the Ontario Insurance Commission's existence, a consensus was reached between government and insurers that where the entire budget of the OIC (now FSCO) was to be funded by insurers based on a pro rata share of premium dollars collected, it would be more equitable for the DR component of this agency to be funded based on consumption of DR services. In that way, insurers with a high market share but relatively low dispute rates would be rewarded and insurers with low market share but high dispute rates would pay the perceived rightful share. Thus, initially a $2,000 insurer filing fee, ultimately raised to $3,000 per arbitration was created, as against a $100 applicant filing fee. Later, a $500 mediation filing fee was created for insurers, with none for applicants.

The problem is that the filing fees for arbitration levied against insurers are significant enough to create financial incentives to throw money at a claim to avoid arbitration. It would not be unfair to say that some unscrupulous representatives use this filing fee as a means of extortion of insurers.

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[11] See *e.g.*, *Yang and ING Insurance Co of Canada* (March 15, 2007), FSCO A05-000722; *Boyer and Allstate* (May 30, 2007), FSCO A03-001739; *Rumak and Personal Insurance Company* (November 5, 2003), FSCO A01-000065, aff'd on appeal.

There can be no doubt that the users should fund the system. However, there needs to be a better model created that does not foster artificial incentives to settle.

More Issues with the Unique Industry Funded Model at FSCO

I cannot leave the above topic without noting the frustration felt surrounding the mediation backlog. The DR managerial staff and the users all knew this problem was about to happen. A 30,000 mediation backlog does not just appear. Rather, the government allowed this problem to fester. It did so because it refused to allow FSCO, a body completely funded by the insurance industry, to hire more mediators. The reason given was that there was a government hiring freeze. Thus, the problem with the unique model emerges. You cannot have an industry funded model housed within a government structure work properly without recognizing that exceptions exist to the usual governmental rules.

In the same vein, lies the thorny problem of independence of decision making by arbitrators, who are appointed by the government, and who are subject to union protection and collective bargaining rules. Some arbitrators take more than a year routinely to release decisions, where there is a mandate to get them released within 85 days. Yet, it would seem that there is no method by which the Director of Arbitrations can compel better performance from certain arbitrators. The administrative powers conferred on a senior regional judge would not seem to have similar application to a senior arbitrator at FSCO for these reasons.

Further, where a provincial chief justice would step in to address issues of discipline respecting a recalcitrant judge before involving the Canadian Judicial Council, there would appear to be no powers conferred on anyone to do the same with arbitrators, and more importantly, a collective bargaining agreement that might preclude any such discipline. .

Standard of Review

Up until recently, the Supreme Court of Canada authority of *Dunsmuir v New Brunswick*,[12] provided that where there was a privative clause in effect, as there is at FSCO, the deferential standard of reasonableness is the appropriate standard of review.

More recently, in *Rogers Communications v SOCAN*,[13] the Supreme Court of Canada addressed the standard of review in instances where a tribunal has concurrent jurisdiction with the Courts at first instance, just as is the case at FSCO. The Court concluded that it would be inconsistent to apply a deferential standard on review of a tribunal decision, and a correctness standard on appeal from a judge's decision on the same issue. [14]

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[12] 2008 SCC 9, [2008] 1 SCR 190.

[13] 2012 SCC 35, [2012] 2 SCR 283.

[14] *Ibid* at paras 14-15. The majority decided as follows:

> [14] It would be inconsistent for the court to review a legal question on judicial review of a decision of the Board on a deferential standard and decide exactly the same legal question *de novo* if it arose in an infringement action in the court at first instance. It would be equally inconsistent if on appeal from a

Because judges of the Superior Court do not appear to be bound by FSCO appeal level decisions,[15] the potential exists for inconsistency in the interpretation of the *SABS* as between FSCO and the courts. In turn, inconsistent interpretations may create the opportunity for "forum shopping" as well as the re-litigation of issues where a question has been dealt with before FSCO at an appeal level but where there is no binding authority before the courts.

The courts' analysis of the appropriate standard of deference owed to FSCO appeal rulings also does not make reference to section 285 of the *Insurance Act*, which permits the Director of Arbitrations to state a case in writing for the opinion of the Divisional Court on any question of law. Presumably, this provision is intended to serve as a vehicle for "fast tracking" the coherent resolution of interpretive issues. Implicitly, section 285 suggests that the Director of Arbitrations operates under the jurisdiction of the Divisional Court in interpreting legal questions, contrary to the reasoning in *Pastore v Aviva Canada*.[16] Indeed, if this were not the case, it is difficult to understand the purpose for that provision. Because the significance of section 285 of the *Insurance Act* was not considered by the court in *Pastore* in relation to the unique context of shared jurisdiction between the courts and FSCO, there may yet be unresolved issues surrounding the question of deference owed to the tribunal and the standard of review.

Parenthetically, had the Director of Arbirtrations sought to state a case to the Divisional Court to interpret critical provisions of the *SABS*, we would likely not have waited more than a decade for clarity of the catastrophic definition, and would not have had a 30,000 mediation backlog caused by a lack of clarity of the MIG and "incurred" definitions for the better part of three years.

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.

> judicial review, the appeal court were to approach a legal question decided by the Board on a deferential standard, but adopt a correctness standard on an appeal from a decision of a court at first instance on the same legal question.
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> [15] Because of the unusual statutory scheme under which the Board and the court may each have to consider the same legal question at first instance, it must be inferred that the legislative intent was not to recognize superior expertise of the Board relative to the court with respect to such legal questions. This concurrent jurisdiction of the Board and the court at first instance in interpreting the *Copyright Act* rebuts the presumption of reasonableness review of the Board's decisions on questions of law under its home statute. This is consistent with *Dunsmuir*, which directed that "[a] discrete and special administrative regime in which the decision maker has special expertise" was a "facto[r that] will lead to the conclusion that the decision maker should be given deference and a reasonableness test applied" (para. 55 (emphasis added)). Because of the jurisdiction at first instance that it shares with the courts, the Board cannot be said to operate in such a "discrete . . . administrative regime".

[15] See *e.g.*, *McLinden v Payne*, 2010 ONSC 6868, 104 OR (3d) 554.

[16] 2012 ONCA 642, 112 OR (3d) 523. In *Pastore*, the Court of Appeal considered the appropriate standard of review on appeal from FSCO and held that a deferential standard of reasonableness was appropriate.

The Right to a Medical Examination

To the extent that section 44 of the *SABS*, addressing insurer examinations, has now been given an increased role in the claims adjudication process, the availability of high quality assessments within the timelines and within the monetary limits imposed by the *SABS*, is also a chronic and serious problem.

Section 44, 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 purposes of assisting an insurer to 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 Wawanesa Mutual Insurance Co*[17] 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.[18] 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 44, finding that notice complying with the section cannot be waived, and that what constitutes "proper notice" will be strictly and technically construed.[19] 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 44 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

[17] (August 10, 2006), FSCO A03-001363, aff'd in part (December 5, 2007), FSCO P06-00003.
[18] See *Al-Shimasawi and Wawanesa Mutual Insurance Co* (May 11, 2007), FSCO A05-02737.
[19] See *Ives and Wawanesa Mutual Insurance Company* (June 22, 2006), FSCO A05-02144.

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 44, provided that the assessment is deemed to be "reasonably necessary" "to determine if an 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 44 does 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 $10,0000 and either permit or foreclose entitlement to enhanced coverage levels for life. Assessments under the different criteria for catastrophic impairment set out at subsection 3(2) (previously subsection 2(1.2)) of the *SABS* necessarily involve a multi-disciplinary approach, and in the case of the definition at paragraph (e), 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.

Now that there is a particular procedure in place pursuant to section 44 of the *SABS* for an insurer who wishes to obtain a paper review, it is not clear on what basis an insurer can obtain a second opinion. It is not clear whether a paper review critique can technically be obtained without following the provisions of section 44. From a fairness perspective, Applicants can seek consultations with as many experts as they see fit, without sharing the existence of such consultations, let alone the contents of them, with the insurer. Yet, insurers, before even undertaking a paper review seem obliged to get permission from the Applicant to even ask for an addendum report seeking to comment on the Applicant's experts subsequently served reports. In the absence of consent from an Applicant, there are questions as to whether an updated report from the insurer's expert is permissible. Yet, it is clear that the insurer's expert cannot testify beyond the four corners of his or her report without an addendum.

Prior amendments to the accident benefits regime have given heed to the mistaken notion that there needs to be a complete balance between insurer examinations and examinations paid for by insurers but at the claimant's behest. This balance issue is a complete fallacy. Most legitimate accident benefit claims with tangible damages at stake either have concurrent tort claims, or have counsel appointed who are willing to invest, on a contingency basis, that the claim has value. Many successful plaintiff personal injury firms spend tens of thousands of dollars on medical assessments without any regard to whether the accident benefit insurer will pre-approve and pre-fund same. If an insurer has conscribed rights of assessment limited by section 44, a significant imbalance can exist in many cases.

Other Inequities

The Ontario Court of Appeal in *Liberty Mutual Insurance Co v Fernandes*[20] has ruled that there is no mechanism for an insurer to get clarity on its obligations. 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 *Insurance 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 ("Designated Assessment Centre") 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).*[21]

The Tort Interface

The *Insurance Act* provides for the deduction by the tortfeasor of past and future collateral benefits, including future accident benefit entitlement. The current regime provides that such a deduction is to be made following any reduction of damages by reason of a liability split.

Strategically, where plaintiffs' counsel want to keep pressure on a tortfeasor's insurer to settle a claim within policy limits, a settlement of the accident benefit claim before trial in tort, removes

[20] (2006), 82 OR (3d) 524, [2006] OJ No 3514 (QL) (CA) [cited to OJ].

[21] *Ibid* at paras 14-15.

pressure from the tort defendant. They get the benefit of the deduction of the settlement amount, thereby reducing the prospect of an excess limits judgment. Most prudent counsel would not remove that leverage.

Further, where the credit of the future benefits comes off after any liability split, a settlement of an accident benefit case before resolution of a tort claim where there is contributory negligence is borderline negligent, and likely clear negligence in some cases. In a case where liability is 75% against the plaintiff, and future accident benefits are settled for $400,0000, there needs to be a judgment in excess of $1.6 million for the tortfeasor to have any exposure.[22]

Thus, where FSCO seeks to control its own processes, including conducting pre-hearings, settlement conferences and arbitration hearings in a timely way, it has become clear that in a large percentage of cases, the arbitration claims at FSCO are 'placeholders' to keep the accident benefit claim alive, without any sincere intention of proceeding with a hearing, and without any sincere intention of settling the proceeding until and unless the tort claim is either already resolved, or in the process of being resolved. This creates an incredible waste of resources.

Offers to Settle and Cooling Off Periods

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 *SABS*.

In the Court of Appeal ruling in the case of *Igbokwe v HB Group Insurance Management*[23] 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 [the settlement regulation] 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.*[24]

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

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[22] This simplistic example assumes the heads of damages match up. The outcome is not greatly dissimilar even if the heads of damages do not precisely match up.

[23] (2001), 55 OR (3d) 313, [2001] OJ No 3018 (QL) (CA) [cited to OJ].

[24] *Ibid* at para 20.

courts. It makes little sense to say that someone in litigation loses their 48 hour cooling off period because of the impact same would have on the administration of justice in the courts, but without regard for the exact same problems that arise at FSCO.

Indeed, there are some experienced counsel who have manipulated the cooling off period at FSCO in the context of a global tort and accident benefit settlement. After negotiating the best deal from both insurers, the tort settlement is finalized with the signature of the Minutes of Settlement, and yet the accident benefit settlement negotiated by the same counsel concurrently, is subject to the cooling off period. We have seen counsel resile from the accident benefit component of the settlement as per the rights conferred under the settlement regulation, even where the consumer protection oriented intent of the cooling off period would seem to have no application.

Harmonization with WSIB

The interaction between section 61 (previously section 59) of the *SABS* 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 61 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 subsection 61(1) applied.

Specifically, subsection 61(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 subsection 61(1) are resolved, with the insurer's payments being protected to the extent that there is an approved assignment from WSIB on the file. 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 61 of the *SABS*. WSIAT has exclusive jurisdiction to determine whether WSIB benefits are available to a worker, and

whether there has been a "bona fide" election to claim damages under section 30 of the *WSIA*, where section 28 of the *WSIA* otherwise eliminates the right to sue. 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 61 of the *SABS* have adopted the position that insurers wishing to defend a claim under subsection 61(1) of the *SABS* 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 61(2) of the *SABS*. 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. While recently, WSIAT has clarified their previously ambiguous and inconsistent position giving right to a statutory accident benefits carrier to have standing before the Tribunal to bring a section 31 application, the practical reality is that from a timing perspective there are still significant problems. Invariably, WSIAT wants to make this determination once, and have that finding bind the tortfeasors.

There are practical reasons why a section 31 application should proceed, where possible, in tandem with a civil action. There are no examinations for discovery 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 for an accident benefit insurer to collect back from WSIB 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, or one who has succumbed to their injuries in the interim, 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. We are counsel on more than one file where, several years after the WSIAT determination barring action, the accident benefit insurers still have not been reimbursed virtually any of the in excess of one million dollars of accident benefits paid on the claim.

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*. Even if an insurer is successful and gets a reimbursement from the WSIB on an assignment, the amounts recoverable are a fraction of the amounts paid out.

This apparent "gap" between the operation of section 61 of the *SABS* and the WSIB scheme was the subject of WSIAT Decision No. 983/07.[25] 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.*[26]

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

[25] 2007 ONWSIAT 1667, online: ONWSIAT <http://www.wsiat.on.ca>.
[26] *Ibid* at para 32.

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 subsection 61(5) of the *SABS*.

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 Decision No. 983/07 creates a strong disincentive for insurers to make interim accident benefits payments when there is a probability that subsection 61(1) applies to the situation and subsection 61(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 within the *SABS* context. It is evident that "proper" handling of claims under section 61 of the *SABS* 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 *SABS* and the *Workplace Safety and Insurance Act*.

ARBITRATION RECOMMENDATIONS:

1. Amend Rule 62.02(4) of *Rules of Civil Procedure* to include decisions of FSCO as being potential conflicting decisions for which leave to appeal ought to be granted, where a court decision is in conflict with a FSCO decision on the same issue.

2. Remove the transparency of arbitration filing fees, and go back to a formulaic approach to the funding of dispute resolution at FSCO, on a twice annual basis, rather than file by file. Further, rather than charge $3,000 per arbitration effective the date on which an arbitration response is due, an insurer should be levied the same fee as the Applicant, and that fee should be equivalent to the fee charged to issue a statement of claim in the Superior Court of Justice. To reflect more accurately the cost of running the DR system, incremental additional charges should be levied against insurers on a stage by stage basis, with a further fee of $2,000 being charged if a pre-arbitration hearing takes place, and a further fee of $2,000 if a preliminary issue hearing takes place, and a further $3,000 to $5,000 if an actual hearing on the merits commences.[27]

3. Enhance the intended use of section 285 of the *Insurance Act* to compel the Director of Arbitrations to state a case to the Divisional Court in limited conscribed circumstances, so as to fast track the development of clear interpretations of the law where the law is in flux in this area more than in any other area in the province.[28]

4. FSCO arbitrators must have equivalent powers conferred upon them as judges have in section 105 of the *Courts of Justice Act* and section 33 of the *Rules of Civil Procedure*, to ensure that insurers have rights to conduct medical examinations in a frequency and of a quality and nature equivalent to that of the claimant, and to bar recovery in the event of a refusal to attend. Rights to paper review evaluations should be the same for Applicant and Insurer.

5. Amend subsection 281(1) of the *Insurance Act* to enable an insurer to bring an Application pursuant to Rule 38 of the *Rules of Civil Procedure* in order to expeditiously determine its rights and obligations under the *SABS* in a particular set

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[27] The exact fees to be charged as proposed herein will require actuarial analysis. They should not be so high as to create a windfall to the government in running the DR system (as was clearly the case with the thousands of mediation fees charged in recent years). There should be an analysis undertaken to establish what the charges should be to break even relative to the current model, where the initial fee charged to insurers will be reduced, but recouped by larger fees as the proceeding and use of more expensive DR resources is pursued. Where the funding of the entire FSCO operation is industry based, any modest shortfall in DR funding by insurers will be offset by market share funding. Where the funding of DR has led to a significant government surplus of funding in recent years, a market share based funding model will ensure greater cost neutrality.

[28] Where the Ontario Trial Lawyers Association (OTLA) and the Insurance Bureau of Canada have invariably sought and received intervener status in critical cases in the field of accident benefits, including *Pastore*, *Kusnierz* and *Hurst*, perhaps the amendment to section 285 should contemplate a stated case be made by the Director of Arbitrations at the collective behest of both organizations.

of circumstances. It is envisioned that this right would be conscribed to fundamental questions of coverage, rather than procedural rights.

6. No insured person who is intending to commence, or who commences an action in tort, shall be permitted to make an election pursuant to section 281 of the *Insurance Act* to arbitrate at FSCO or privately.

7. The Settlement Regulation shall have no application to any claim that is either in litigation or arbitration.

8. Insurers who possess a valid WSIB assignment shall be deemed to also take an assignment of the rights of the injured worker, and the WSIB shall not have the right to demand the active involvement of the injured worker in the application process. Alternatively, section 52 of the *SABS* should be amended to give an insurer a right of repayment for any amounts paid pending disposition of the WSIAT and section 59 issues, and net of any shortfall of recovery on an assignment.

9. Efforts must be undertaken to strengthen the wording of section 61 of the *SABS* to guard against bad faith conduct by insured persons from dragging out proceedings to obtain accident benefits. When an assignment is sought by an accident benefit insurer, that should trigger an obligation on the Plaintiff to issue their statement of claim in tort within a finite period of 30 to 60 days, and to expedite the ensuing tort litigation so as to ensure that examinations for discovery are completed on an expedited timetable so as to enable the parties to commence their WSIAT hearing immediately. Section 61 should be re-drafted so as to permit an accident benefit insurer to stop funding accident benefits pending the commencement of the WSIAT hearing in the event these strict timelines are not met. There needs to be better meshing of the wording of section 61 of the *SABS* and section 31 of the WSIA.[29]

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[29] Subsection 61(1) of the *SABS* reads

> 61. (1) The insurer is not required to pay benefits described in this Regulation in respect of any insured person who, as a result of an accident, *is entitled to receive benefits* under the Workplace Safety and Insurance Act, 1997 or any other workers' compensation law or plan. O. Reg. 34/10, s. 61 (1).

Subsection 31(1) of the *WSIA* reads

> 31. (1) A party to an action or an insurer from whom statutory accident benefits are claimed under section 268 of the *Insurance Act* may apply to the Appeals Tribunal to determine,
>
> (a) whether, because of this Act, the right to commence an action is taken away;
>
> (b) whether the amount that a person may be liable to pay in an action is limited by this Act; or
>
> (c) *whether the plaintiff is entitled to claim benefits* under the insurance plan.

[emphasis added].

10. Obligations must be imposed on the WSIB to process requests by insurers for reimbursement pursuant to their assignments within a finite and reasonable time frame.

CONCLUSION

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, it is no surprise that 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 *SABS* 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. While the WSIB interface does not affect a large percentage of claims, those claims that it does affect, it tends to affect in outrageously unfair ways. 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.

I would be most pleased to speak further to any of the above issues at your convenience.

Yours very truly

Eric K. Grossman