THE IMPACT OF BILL 15 AND WHY EVERYONE SHOULD BE WORRIED

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The *Fighting Fraud and Reducing Automobile Insurance Rates Act*, also known as Bill 15, was passed into law on November 20, 2014. This Act has received the support of the Liberal majority and the Progressive Conservatives, but was opposed by the New Democrats.

To be certain, this new law will do a lot of good things to help reduce automobile insurance premiums in Ontario. Much of what is contained in the law comes straight from the *Auto Insurance Anti Fraud Task Force*'s recommendations, including greater province wide regulation of tow truck operators and storage facilities. The rest of the legislation has its genesis in the report of the Honourable Justice Doug Cunningham respecting an overhaul of the Dispute Resolution System at the Financial Services Commission of Ontario (FSCO). While there is not universal agreement that this Act will help fight fraud and reduce insurance rates, one must look at who is complaining and why to get a better understanding of the law.

Tow truck drivers have been regulated by municipalities for the most part, with little enforcement of the patchwork of regulations that did exist. That this group is complaining about the changes, is not a big surprise.

Mediators and arbitrators at FSCO are unhappy, as their positions will soon enough become redundant. However, a system which created year long backlogs to conduct mediations, which mediations were generally perfunctory events to allow one to move on to the next stage, correctly

needed to be addressed. Further, arbitrators who could take years rather than days or weeks to generate decisions, where their status as public service union employees left the DR management powerless to deal with the recalcitrance of some in their rank, left Justice Cunningham with the reasonable conclusion that the system was irretrievably broken.

What will come out of the ashes of FSCO stands to be a more streamlined and more efficient system of delivering dispute resolution to be housed at the License Appeals Tribunal (LAT). No longer will there be a one size fits all approach to arbitration. Small, single issue cases will be dispensed with quickly and efficiently. Complex cases will not be allowed to bog down into multiple week hearings, and there will be strict timelines to get cases heard, and decisions rendered. Arbitrators will be appointed by Order in Council and therefore will be obliged to be more accountable to the government in terms of the mandate of speed and efficiency.

All of this is good.

So why is there contention about this new law, with some insurers adamant that it must be enacted without amendment or dilution, others less certain that it is a good idea, and lawyers on both sides of the Bar concerned?

It comes down to one section: subsection 280(3) of the Insurance Act, removing the right to sue in a court proceeding for accident benefits.

In the province of Ontario, there has never been a deprivation of the right to go to court to pursue one's remedy against an insurer. Since enhanced no-fault benefits were introduced in 1990, 24 years ago, injured persons have

had the right to choose whether to go to court or to an administrative tribunal to pursue their denied claims. Before then, going to court was their only remedy.

Even if all of the other provisions in Bill 15 are supportable and prove beneficial to consumers in this province by way of lowered insurance rates, the removal of the right to choose to go to court will not lead to reduced premiums.

The goal of Bill 15 is rate stability and fraud reduction. The abolition of the right to sue in every case will actually do the opposite. At its simplest, where insurers currently and have always had the recourse to sue fraudulent claimants for repayment of ill begotten accident benefits, Bill 15 will actually remove that right. So, ironically, the “Fighting Fraud” component of the Act will, perhaps inadvertently, do the opposite.

Accident benefits in Ontario are the richest of anywhere in the country, and indeed, some of the richest in the world. We have a system which provides in excess of $2.5 million in benefits to accident victims without regard to fault in the most serious cases. Some suggest that we should simply strip down the accident benefits system, and make it less generous. That might be an easy solution, save for the reality that in the 24 years since this system was introduced, the government has effectively downloaded much of the care of accident victims from OHIP to auto insurers. All physiotherapy and chiropractic care has been delisted. It is not hyperbole to say that prior to June 1990, when no fault benefits for medical and rehabilitation were for 4 years or $25,000 of coverage, that virtually everyone’s coverage ended after 4 years before the limits were used. OHIP paid for virtually everything.

Allowing decisions of entitlement to be made by an LAT tribunal on a paper record will certainly save legal costs. But what will it do to payouts on claims? insurers can and will recite what it costs to pay their counsel to fight cases in court and at FSCO, and will correctly note that they will pay less to their counsel to fight cases at a streamlined LAT tribunal. When an LAT tribunal decides that a $1,500 mattress claim is payable based on a perfunctory hearing, it is generally reasonable to say, as Justice Cunningham does, that for $1,500, proportionality dictates this approach. But what of the case where the mattress claim is part of a bigger picture? Does it matter that the mattress claim is presented by a claimant who is on route to the hospital for a previously scheduled back operation when the no property damage 'car accident' occurs? What will the finding that such a claim is payable do to the rest of the claims the claimant will be presenting, for loss of income, and possibly even in tort? You can be sure that the finding that the mattress is payable will be trumpeted by the claimant and his or her counsel with each successive claim, and any effort to re-argue causation, even in the tort claim where the tortfeasor was not a party to the initial LAT process, will be rebuffed.

A simple decision on the mattress will impact the way causation is dealt with in the tort claim. If causation is found to exist, the tort defendant will say that he did not take part in that LAT proceeding, the decision is not binding on him, and he would be right. If causation is found not to exist, the claimant will say that despite the findings in the LAT proceeding causation is still live in the tort claim, and he too would be right. The causation issue will be re-litigated in the tort case. The same witnesses will be called. A system where

the same exact issues will need to be litigated in different places at different times will NOT create efficiencies which can lead to reduced rates.
The same exact issue arises with shortfalls in payment of income replacement in accident benefits that fall to the tort, and shortfalls in attendant care (where there are statutory limits and caps in accident benefits) that fall into tort.

While some would say that this is the case currently, with split cases between FSCO and the courts, but there are two distinct differences. Firstly, the claimant has the choice to split the case, which choice is being removed. Secondly, while the FSCO proceeding looks a lot like a court case, with the right to call as many witnesses on either side as is required by the parties to prove a case, the approach taken at the LAT will be decidedly different, with the vast majority of cases such as mattress claims being disposed of summarily with written submissions and no live evidence.

The removal of the election of forum by the claimant's representative is not the big problem, where often times, some form of advantage has been sought to maintain separate proceedings between FSCO and the court. The problem is the prohibition of the right to sue for accident benefits, even where both insurer and insured are in agreement that the dispute should be joined in court with the tort claim.

The same exact issue arises with shortfalls in payment of income replacement in accident benefits that fall to the tort, and shortfalls in attendant care (where there are statutory limits and caps in accident benefits) that fall into tort.

A dollar saved in accident benefits often does not get saved ultimately, since it gets added to the tort claim. So, if the mattress is not allowed to be claimed by way of accident benefits, that does not mean that the very same mattress (or attendant care expense or income loss) claim cannot be advanced again as part of the tort claim. So, on that basis, how is it that having these claims running separately in court for the tort and at LAT for the accident benefits creates any savings?

Many may be unconvinced by the mattress example. While it may be the simplest one to understand, it is likely not the best example of the problem. Unfortunately, the insurance system in Ontario is neither easy to navigate nor simple to explain. Injured victims have the right to pursue the at-fault motorists by way of tort and to pursue a basket of statutory benefits, regardless of fault, from their own insurer. The two systems work hand-in-glove. Every dollar an accident benefit carrier pays out acts as a credit to the tort insurer. The credit applies after liability is established. So if an accident benefit carrier pays out $50,000, and the tort claim is assessed at $100,000, but there is a 50-50 split in liability between the two drivers of the cars, the $50,000 AB settlement offsets the entirety of the tort award.[1] It would be negligent for a lawyer acting for an accident victim to settle the accident benefit case in advance of that tort case because that realizes that credit. It never happens, and this change to the law will not cause it to happen. Rather, you will have two proceedings, one at the tribunal, and the other in court; whereas now one of two things happen, neither of which will be permitted under the new law. Either the cases are not split, and you would have both cases dealt with at once in court. Or, the accident benefit

[1] This is a modest over simplification of the issue, where the credit requires an 'apples to apples' comparison. Income replacement benefits will act as a credit against income loss damages, but not, as an example, against general damages for pain and suffering.

arbitration at FSCO would be ‘parked on the sideline’ and continually adjourned to allow the tort case to catch up with the accident benefit dispute. Another example of a problem created by this new law deals with the issue of an insurer’s bad faith. Now lawyers who believe an insurer needs to be held to account for unfairly treating their insureds sue in court for this relief. The underlying accident benefit claim that was denied is obviously critical by way of foundation for proving that bad faith. There can be no doubt that with this new law that the victim would have to go to the LAT for the denied benefits rather than to court. Depending on the benefit at issue, there may be a paper-review decision, an abridged-arbitration decision or a full hearing, and the LAT decision would be made on entitlement. If the decision favours the accident victim, that person can then still go to court in a separate proceeding to claim bad-faith damages.

The Judge who hears the bad faith law suit, will have not heard the part of the story leading up to the LAT decision that the benefits were payable. What happens if that judge disagrees with those findings? What if the judge wants to hear some of the same evidence over again? Does any of this lead to efficiency? And how much extra will it cost to have counsel acting in these separate proceedings?

In light of the Court of Appeal’s decision in October 2014 in ***Mader v. South Easthope Mutual Insurance Company*** [2014] ONCA 714, it is conceivable that it will be found that this new law has completely ousted the Court’s jurisdiction to hear a bad faith claim respecting statutory accident benefits. The Court’s analysis of “independent actionable wrong”, written by Justice Hourigan on behalf of the unanimous panel, is reproduced below:

In my view, it is clear that the appellant has not fulfilled either of the statutory preconditions to the commencement of a court proceeding. The appellant submits, however, that she has sued not only for breach of contract, but for mental distress, breach of the duty to act in good faith, and conspiracy. She submits that these latter three claims do not require an FSCO mediation before an action can be commenced.

[43] It is the appellant's position that her mental distress and bad faith claims are inextricably linked. She alleges that the respondent coerced her into signing the settlement and that by persisting in denying her benefits and refusing to set up a DAC assessment for seven years, the respondent acted in bad faith. The appellant further alleges that the respondent and two of its representatives conspired to injure her by closing her file.

[44] The appellant submits, therefore, that her claims result from the respondent's denial of her procedural rights, rather than the denial of benefits. In other words, her mental distress and bad faith claims are independent causes of action, which are not in respect of entitlement to or amounts of benefits. Accordingly, the appellant submits that she is not required to bring these claims to an FSCO mediation.

[45] In some instances, breach of an insurer's duty of good faith or intentional infliction of mental distress can constitute an independent cause of action: *Whiten v. Pilot Inusrance Co.,* 2002 SCC 18 [2002] 1 S.C.R. 595, at para. 82; *Prinzo v. Baycrest Centre for Geriatric Care* (2002), 60 O.R. (3d) 474, at paras. 37-39, 64. However, neither is a separate actionable wrong in this case.

[46] The reasoning of this court in *Arsenault v. Dumfries Mutual Insurance Co.*, (2002), 57 O.R. (3d) 625 (C.A.), is instructive on this point. The issue in that case was whether a claim for bad faith damages arising out of an insurer's termination of no-fault accident benefits was subject to the two-year limitation period set out in s. 281(5) of the *Insurance Act*. Answering this question necessitated a determination of whether bad faith claims were caught by s. 279(1) of the Act.

[47] Justice Abella noted that in s. 279, the legislature mandated that disputes "in respect of" any claim to no-fault benefits must be resolved in accordance with ss. 280 to 283 of the Act. Relying on the Supreme Court of Canada's decision in *Nowegijick v. The Queen*, [1983] 1 S.C.R. 29, Abella J.A. commented, at para. 16, that the use of the phrase "in respect of" is probably the widest of any expression intended to convey some connection between two related subject matters. She determined, at para. 17, that "any and all disputes about an insurer's refusal to pay no-fault benefits, including disputes which allege the insurer's bad faith in connection with that refusal" were caught by the scheme in ss. 280 to 283.

[48] Abella J.A. went on to conclude, at paras. 19 and 21:

> If I am wrong in concluding that bad faith claims in connection with no-fault benefits refusals are subject to the procedures and time limits set out in ss. 280 to 283 of

> the *Insurance Act*, I am nonetheless of the view, based on the pleadings, that this appellant's claim is not an independent, actionable wrong, but is in fact exactly the kind of dispute over no-fault benefits entitlements contemplated by the dispute resolution scheme in the Insurance Act... Moreover, had the dispute been arbitrated, it was open to the arbitrator under s. 282(10), if it was found that the insurer had "unreasonably withheld or delayed payments", to award an additional lump sum.
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> …
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> Ms. Arsenault's characterization of the insurer's refusal as bad faith conduct is merely an attempt to circumvent the mandatory requirements of the dispute resolution scheme in the *Insurance Act* through the guise of linguistic reformulation. Her allegations, distilled, are that the refusal was inappropriate in the circumstances, the very issue contemplated for resolution under the scheme, and a claim that is clearly subject to the two year limitation period set out in s. 281(5).

> [49] This analysis applies in the present case. The claims asserted by the appellant all flow from the denial of benefits. At their essence, they amount to nothing more than a claim that the appellant was wrongly denied benefits to which she believes that she is entitled to receive. This is precisely the type of claim contemplated for resolution by the procedure in ss. 280 to 283 of the *Insurance Act.*
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> [50] Indeed, s. 282(10) of the *Insurance Act* provides that if the parties proceed to arbitration and the arbitrator finds that an insurer has unreasonably withheld or delayed payments, the arbitrator shall award, in addition to the benefits to which an insured person is entitled, a lump sum of up to 50 per cent of the amount to which the person was entitled at the time of the award. This subsection makes clear that the procedure in ss. 280 to 283 is not restricted solely to claims for benefits, but is also designed to include claims related to the manner in which benefits were administered.
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> [51] The pleading of a conspiracy does not transform the appellant's claim into an independent actionable wrong. The facts underlying the appellant's conspiracy claim are the same as those underlying the rest of her claims. The object of the alleged conspiracy was to deny the appellant her benefits.

Thus, if there is no 'independent actionable wrong', as per *Mader,* there would be no right to sue in Court, and the LAT would have exclusive jurisdiction to hear all issues relating to the suspension or termination of accident benefits. To date, we do not know what the jurisdiction of LAT

arbitrators will be to award extra contractual benefits akin to the 'special award' jurisdiction granted to FSCO arbitrators. This will be one of the more important remaining questions to be answered with the promulgation of the regulations.

This LAT tribunal process that will be promulgated by regulation to this new Act critically speeds up the dispute resolution process. That is a good thing in most cases, but in some cases, people have strategically decided that they do not want to resolve their accident benefit claim. They want to keep it live because they have a pending tort claim, and their tort claim critically relies upon being able to argue that they have not finally disposed of the accident benefit claim, showing the tort defence that there is still an ongoing dispute. If they settle it in advance, they lose that argument. There is a credit that is created for the tortfeasor as a result. They prefer to leave the claim in limbo and deal with the tort and the accident benefit concurrently.

Insurers are very quick to point out the cost of litigation relative to the cost of arbitration. But they do not count on the number of cases that get parked on the sidelines, to everyone's ultimate benefit, at FSCO, while the tort case catches up. There are cases brought to protect a limitation on a denial, that neither side is keen on having decided, where each side faces a risk of losing. Causation is all or nothing in many of these cases. "Catastrophic impairment" is all or nothing. Wise litigants recognize that a compromise resolution is often better than the risk of a 'nothing' result. If you force arbitrations ahead, as Justice Cunningham's report suggests (and as the LAT regulations undoubtedly will require), there will be additional costs resulting from the increased number of hearings. We hear statistically that 98% of the cases get settled. This new LAT system will cause more of them

not to get settled, and that will add cost. In my view, the cost implications arising from the removal of the right to sue for accident benefits has not been adequately examined to date.

Remember, just because someone is found to be able to return to some occupation that they may be suited to by reason of education, training or experience (which is the test for post 104 week income replacement benefits), that does not mean that they do not have a viable claim in tort for future loss of income. Why should the shortfalls be adjudicated at the LAT and then be left to the tort defendant to contend with in court, where again, all of the same experts will be called a second time to deal with the evidence. On this point, Justice Cunningham, in his current role as a private mediator, should agree that the presence of tort and accident benefit insurers under one roof is the best recipe for a successful and fair settlement of both claims. Yet, the walling off of one system from the other by the barring of lawsuits for accident benefits, means the issues are not joined, and the insurers are not together. Inefficient? Expensive? You don't know the half of it – when one side of the file settles without the other, the overlapping aspects of the claims, like credits for future income replacement benefits as against future loss of income, magically and mysteriously find ways of not overlapping, and credits that one would expect to see from one insurer to the other, disappear. The cost to the industry when this happens is enormous.

Insurers can and do measure their payouts to their counsel for expenses, but do not measure well what they save in indemnity payments when their counsel effectively represent them.

There stands a decent chance that the new *Act* will cause accident benefits claims to be dealt with more efficiently and inexpensively, and that they will be resolved with less legal fees incurred. However, in those cases where there is a viable tort claim, whatever is saved by early closure of the accident benefit claim will simply be tacked on to the tort claim in damages. In addition, plaintiff's counsel will charge 15% for party and party costs for this added tort recovery, where in accident benefits, costs are not paid on this scale. Further, in some cases, the added tort exposure will creep up to expose an insured to an above limits tort claim, that, if the accident benefit claim were maintained in the same law suit as the tort, would not be settling in advance, and not allowing for the creation of the excess claim in tort. Will insurers factor these added tort exposures as being directly resulting from this removal of the right to sue for accident benefits? They have certainly given no indication that they have even considered this problem during the consultation phase of this Bill.

The Advocates' Society, Ontario Trial Lawyers' Association and the Canadian Defence Lawyers organization were all in agreement that there be exceptions added respecting the removal of the right to sue found in the Act. The changes proposed, were:

> a) Subsection (3) does not apply to claims streamed by the Registrar of the LAT into the complex stream, such that a claimant shall have the option to opt out of arbitration and commence litigation within 20 days of being advised that they fall within the complex stream;
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> b) Subsection (3) does not apply to claimants who have commenced a court action in tort, and who wish to include their accident benefit issues in their litigation; [this provision can be optional or, indeed, could be mandatory, whereby claimants who have started a tort claim must not split their cases into two fora]

c) Subsection (3) does not apply where a claimant seeks to sue an insurer for extra contractual damages for bad faith. In such circumstances, the underlying benefits must be included in the court action in which they seek these damages and not adjudicated at the Licence Appeal Tribunal;

d) Subsection (3) does not apply where either a claimant or insurer seeks a determination of a pure question of law, pursuant to Rules 21 and 38 of the *Rules of Civil Procedure*;

e) Subsection (3) does not apply where an insurer seeks to assert a claim for repayment by reason of material misrepresentation or fraud.

All insurers wanted changes to the DR system. Only a few were adamantly opposed to the above exceptions being added by way of amendment to the draft bill. Where those adamantly opposed made their views known, it became clear that the government needed to heed those concerns if they were going to stand any chance of maintaining their promise to cut premiums by 15% by the fall of 2015.

Immediate savings will be had with the removal of mediation entirely from the system, and by reducing tow fees and storage costs. The increased costs to the system as noted herein will undoubtedly hit the system, but will do so well beyond the timeframe that the government is currently concerned with. That probably means that the concerns raised here will be left to be dealt with at a much later date, likely long after the problem is determined to be costing the industry too much money.

Now that the issues have been identified, and the potential easy solutions rebuffed, how should those working within this automobile insurance system deal with these changes?

The latest word is that the LAT will not be up and running before October 1, 2015. It will take time to create the new system, including rules of practice, and procedures such as those mandated by Justice Cunningham. Many of those involved in the drafting suggest that October 1 is too soon to put everything necessary in place.

There will likely be a tug of war between FSCO and LAT where there will be an overlap in the two systems. FSCO will be under tremendous political pressure to wind down their file load as quickly as humanly possible, while the LAT will have regulatory mandates to deliver decisions with lightening speed. Where the same practitioners will necessarily practice in both places, short of successful cloning experiments, no one is looking forward to how this plays out.

The new LAT process will be welcome for those cases where an individual is denied 6 sessions of treatment and wants to take them now, and wants that issue disposed of promptly. It will be ideal for these isolated disputes, of which there appear to be some but not terribly many. For the rest of the disputes that will be heading to the LAT, the new process will likely be exceedingly challenging, and will require a great deal of education to both insurers and claimants. Where claimants are accustomed to addressing production issues during the arbitration process, the new LAT process intends to have all productions dealt with before arbitration is sought. The Registrar will act as a gatekeeper, denying entry o the process if all productions are not in hand. Where insurers are accustomed to retaining counsel only after an arbitration is commenced, and then having counsel review the file and determine whether any documentary production is missing, the time for retaining counsel will necessarily be much earlier if the goal is to have

productions addressed by the Registrar at the time of application. If arbitrations are supposed to take place within a few weeks or couple months of the commencement of the process, plaintiff's counsel will need to strategize as to when that claim should be started, and should be more or less ready to proceed to hearing before so doing. In order for insurers to have substantive responses to claims, their counsel will need to know the file before the claim is formally commenced at the LAT, since timelines would not allow them the opportunity to learn them after.

If insurers continue to retain their counsel only after arbitration is started, there is a risk that they will face an uphill battle in preparing to defend the claim being dealt with in an expedited hearing. Further, there is concern that the window of opportunity to procure the productions that have been omitted by the other side will close even before they are retained. With little chance to secure adjournments of the hearing after being retained at the time of commencement of a fast moving proceeding, this will also create huge concerns to counsel. Of course, the devil will be in the detail respecting these issues once the LAT sets up its processes and rules.

Where the LAT process is expedited, and where there will be no recourse to attach cases to the tort claim in court, either issues will arbitrated that now are not arbitrated, or there will likely need to be tolling agreements reached with plaintiffs to cause them to let their AB issues sit on the sidelines until the tort is ready to talk. Tolling agreements, which extend the time a claimant can commence an arbitration beyond the two year denial of a claim will be a necessary evil for insurers to avoid many of the calamities predicted herein.

Lastly, tort defence counsel will need to take a broader view in assessing their exposure to claims. The *Insurance Act* only allows a tort defendant to challenge an AB settlement if it is made in bad faith. Note, the mistaken belief, emanating from a predecessor version of the *Insurance Act* is that it is not sufficient to prove that the AB settlement was 'improvident'. Bad faith is a very high hurdle.

Where the LAT will be pushing their arbitrations faster, how can a tort defendant say that a plaintiff is obliged to prosecute such a claim through arbitration (and appeal) once a denial is made? Where there is a viable tort claim without a liability issue, or without any real risk of depleting third party tort limits, why would a Plaintiff's counsel pursue the AB carrier, only to reduce the payout in tort? More plaintiff's counsel will likely offer an assignment to the tort defendant to assume their claims for accident benefits rather than pursue them directly. If a tort defendant refuses that offer of an assignment and the plaintiff settles the accident benefit claim modestly thereafter, how much harder would it be for the tort defendant to prove the settlement was made in bad faith? What will happen where tort defendants offer to defray the cost of pursuing an accident benefit carrier by way of separate proceeding at the LAT – will this lead to accusation of maintenance and champerty, and more importantly, would such accusations not be accurate?

All of this will cause more tort claims to have far greater exposure, and potentially exposure that exceed tort limits, thereby putting the insureds at risk in cases where they currently are not.

I have been accused by many of being Chicken Little respecting my concerns about this change. I hope I am proven to be. I have looked hard at what I am

missing in my analysis. There are clearly a number of things that are positive, and that will save time and money. Apart from efficiently dealing with those few legitimate 'one issue' disputes at the LAT in a very timely way, the LAT's summary process will efficiently dispense with the 'bottom feeder' disputes brought be a class of claimant's representatives that neither the industry nor most self respecting counsel want anything to do with. In the current model there is economic coercion in the face of $3,000 filing fees at FSCO to respond to arbitration applications, to say nothing of extensive legal costs getting ready to fight a protracted arbitration. In a streamlined LAT proceeding, that economic coercion will hopefully disappear. Insurers will not have any reason to 'throw nuisance money' at these cases, where to run them will cost them very little, relative to what it currently costs at FSCO.

All of this is to say that it would be helpful if the industry tried to measure costs to the system in a holistic way rather than on one line item. While the cost to defend an action in court is higher than in an arbitration, that may not be the only piece of data to review when deciding that the removal of the right to sue is going to save the industry money. It would behoove the industry to look at the potential additional costs, including the cost of running more cases through the LAT than are currently being run through FSCO, and more importantly, in tort and in accident benefit indemnity payouts.

Even my plaintiff counsel colleagues would say that a system which does not generate reasonable profits for insurers cannot work on a sustained basis. We all want lower auto insurance premiums. All of us that are committed to working in the system want a system that is fair and efficient for all users. Hopefully, while continued collaboration is being undertaken to draft the critical regulations to this new *Act*, more thought can be given to these

potentially daunting problems, with a view to making this fix workable on a sustained basis into the future, rather than it just being the next most recently failed effort to fix the system.