



ARE ACCIDENT BENEFITS ASSESSMENTS NO LONGER ADMISSIBLE IN A TORT ACTION?

By Cary N. Schneider

LOSS TRANSFER INDEMNIFICATION

By Robert A. Robinson



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Your comments are appreciated and if there are any accident benefits or tort topics that you would be interested in reading about, please feel free to [email](#) me and I will certainly explore the possibility of writing an article.

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The decision of *Beasley v. Barrand* (2010) has changed the landscape in which we practice. Although the decision deals with a case that was on the verge of going to trial, this case will affect our decisions as to whether to conduct a defence medical assessment and with whom. Specifically, this case deals with the admissibility of accident benefits insurer examinations in the tort world. An insurer who decides to rely on an accident benefits medical assessment at trial may find that they are left without a medical expert.

In this case, the tort defendant sought to call three medical assessors who prepared reports on behalf of the accident benefits insurer at trial. The accident occurred in 2002, the medical reports were generated in 2003, and the trial was scheduled to proceed in 2010. The Judge for a variety of important reasons, found that these reports were inadmissible. It is important to understand the reasons articulated by the Judge in order to see whether your particular file falls within the reasoning, and if so, whether anything can be done to change it.

Understanding The Reasoning

Since these reports were created for the purposes of accident benefits, the Court found that the Plaintiff will need to undertake a laborious, time-consuming, and unnecessarily complicated description, for the benefit of the Jury of the statutory accident benefits scheme. He found that the additional time, complexity and expense necessarily involved outweighs the probative value of allowing these doctors to testify.

These reports were considered to be

“snapshots” of the Plaintiff’s situation more than seven years ago. The court found that they can be of little, if any, help to the jury in assessing the Plaintiff’s medical and vocational progress since that time.

The Court then undertook a detailed analysis of the impact of Rule 53.03 which came into affect January 1, 2010. This Rule requires any party who intends to call an expert witness at trial must serve every other party to the action with a report signed by the expert which contains specific information. The Judge found that the new Rule “advances the law that has been developing in recent years toward reigning in the growing use of and reliance upon the evidence of experts at trial”. In addition to the proliferation of expert reports in recent years, it was also found that “a common complaint was that too many experts are no more than hired guns who tailor their reports and evidence to suit the client’s needs”. The Judge found that the rule change was in part designed to eliminate the practice of tendering opinion evidence of questionable value at trial.

In this case, the three medical reports in question were commissioned by an accident benefits carrier who has no stake in the trial and their specific instructions are not entirely clear. At the request of tort defence counsel these three doctors have now completed the form required by Rule 53.03; but the forms were not completed entirely accurately. The Court stated that the “... letters and the forms

sent are inaccurate and confusing. More troubling is the fact that the doctors appear to have signed the forms without reading or understanding their content”. These medical reports were found not to comply with the new Rules and accordingly, not admissible.

Analysis

As I see it, the Court refused to allow these three doctors to be called as witnesses at trial for three fundamental and interrelated reasons: (1) the relevance of these reports (2) the goal of the Court to reduce the number of experts testifying at court and (3) technical compliance with Rule 53.03. Insurers ought to consider whether the rationale behind the Court in this case would affect their specific files.

Firstly, the reports were not considered relevant in light of the fact that they were 7 years old and dealt with matters that were in the accident benefits context as opposed to tort. This will be a difficult hurdle for insurers to overcome. Accident benefits carriers often have claimants assessed within one year of the accident by multiple assessors for multiple reasons to determine entitlement to benefits. In the tort world, it is not uncommon for a matter to proceed to trial 4-6 years after the accident occurred (if not more). So, we will always be dealing with medical reports that are old. Also, we will always be dealing with a situation in which the accident benefits world will need to be explained at trial; assuming that the accident benefits

carrier is not a defendant.

The best course of action to address this concern would be to attempt to rely on a more contemporary accident benefits report that is on point. It is more likely that a more recent report addressing the claimant's entitlement to income replacement benefits will be considered to be relevant, as opposed to a report generated six months after the accident addressing the claimant's need for treatment.

Secondly, if the goal of the Courts is to reduce the number of experts who testify at trial, then this will be difficult to overcome. Perhaps the best strategy is not to seek to call numerous accident benefits assessors testify at the tort trial, but rather pick one or two specific unique assessors. For instance, the opinion of a vocational assessor may be considered to have value to the Court as she will opine on whether the claimant has the skill set to perform a variety of jobs.

Thirdly, it may be difficult and costly to have the accident benefits assessor comply with Rule 53.03. Since this doctor has not been retained by the tort defendant, it may not be worth his while to complete these specific forms. Moreover, the assessor may need to re-write parts of his report in order to comply with this Rule. A doctor may be reluctant to do this in light of the fact he surely would not remember anything specific (if at all) about the claimant. If he does re-write part of his report, this sets himself up for effective cross-examination onto how he is "changing" his report so many years later.

If a tort defendant wants to try and rely on the accident benefits assessments the best course of action is to ensure that the Rule 53 forms are done properly, and choose reports that need little to no substantive alteration.

One means of addressing all of these issues is simply retain the accident benefits assessor to evaluate the claimant again from a tort perspective. If the tort insurer likes the assessment performed by the accident benefits assessor, then why not retain this same assessor to draft a tort report? The problem here is at least twofold.

First, there is a potential conflict of interest for the doctor to take a retainer from the accident benefits carrier and then a separate retainer from the tort defendant. Secondly, there would be a viable argument to assert that there is an apprehension of bias. The tort defendant is choosing to retain this doctor to write a report because it already knows what his opinion is. This is exactly what the new Rules are trying to prevent from happening. The Rules are trying to increase impartiality. An astute Plaintiff counsel will have a field day cross-examining the doctor with regards to an apprehension of bias. On the flipside, there may be cases in which the tort defendant may cross-examine a Plaintiff assessor if he does the same thing. What's good for the goose is good for the gander.

Conclusion

What resonates from this decision is the goal to streamline trials to reduce the number of experts called, ensure the relevance of the

assessments, and to add teeth to the new rule 53.03. Although an accident benefits assessment may be very helpful to a tort defendant, it may never see the light of day. Accordingly, steps must be taken to try to insure that the accident benefits reports will be admissible, or simply to generate one's own reports. The latter strategy is certainly easier and more efficient. It will also be more costly. Since about 99% of all cases settle, often a tort defendant will not obtain a defence medical assessment as it will simply rely on the conclusions reached by the accident benefits assessors. In light of the

Beasley decision the safe bet is for the tort defendant to retain its own defence medical assessments and assume that the accident benefits medical report will not be admissible.

Sharp Plaintiff counsel may now move cases closer to trial where there is no defence medical assessment and use this case as the proverbial "jackhammer" to try and negotiate a favourable settlement. Savvy insurance adjusters will be aware of the pitfalls of this decision, and address their files accordingly, to ensure that the defence will have a doctor who can testify at trial on their behalf.

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By Robert A. Robinson



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statutory accident benefits paid to their insured's in certain accidents involving motorcycles and cars, or cars and heavy commercial vehicles.

Section 275(1) of the Ontario *Insurance Act* provides:

- 1) The insurer responsible under subsection 268 (2) for the payment of statutory accident benefits to such classes of persons as may be named in the regulations is entitled, subject to such terms, conditions, provisions, exclusions and limits as may be prescribed, to indemnification in relation to such benefits paid by it from the insurers of such class or classes of automobiles as may be named in the regulations involved in the incident from which the responsibility to pay the statutory accident benefits arose. Idem

RECOVERABLE PAYMENTS v. LOSS CONTROL EXPENSES

Section 9 of Regulation 664 under the Ontario *Insurance Act* provides that loss transfer recovery is available to insurers for

Under subsections 275(2) and (3), such indemnification shall be made according to the respective degree of fault of each insurer's insured as determined under the fault determination rules, and no indemnity is available for the first \$2,000 of statutory accident benefits paid.

While it was clear under OMPP that insurer's medicals/IMEs conducted by the insurer paying statutory benefits, as well as surveillance and other loss control expenses, were not recoverable under the loss transfer provisions of the *Insurance Act*, OIC Bulletin number 11/94 which followed the introduction of a new and more comprehensive *Statutory Accident Benefits Schedule* under Bill 194, stated, in part:

Which statutory accident benefits may be the subject of a loss transfer indemnification request?

First party insurers are entitled to be reimbursed for all accident benefit payments made under the Statutory Accident Benefits Schedule, subject to the \$2,000 deductible discussed below. Now that the new Schedule is in effect, loss transfer is now available for the following kinds of benefits:

- The cost of any assessment conducted under the Schedule
- The cost of services provided by a case manager related to the co-ordination of medical, rehabilitation and attendant care services; and
- All expenses covered by the Schedule.

In the case of *Jevco v. Prudential*, (January 13, 1995), an arbitration under the OMPP regime, Arbitrator Ayers addressed the issue of reimbursement of Jevco's payments for medical examinations and transportation and accommodation expenses related to a three-day insurer's assessment. Jevco relied upon the wording of section 275 of the *Insurance Act* which permitted indemnification "in relation to such benefits paid by it". Jevco argued that the wording "in relation to" was much broader than "for", and therefore the claimed expenses were recoverable. Arbitrator Ayers drew a distinction between insurer exams and DAC assessments, which had been introduced with the Bill 164 revisions to the SABS, noting that DAC assessments were to be totally independent of both the insurer and the insured and were presumably for the benefit of both. He also noted that the DAC expense could be triggered by either the insurer or the insured and thus the costs of same should be subject to loss transfer. On the other hand insurer's examinations were part of an insurer's loss control measures and were usually of little or no benefit to the insured. He found, therefore, that Jevco was not entitled to reimbursement for the costs of its examination or the related travel and transportation expenses. The case was appealed and the appeal was heard by Mr. Justice Mandel, (1995) O.R. (3rd) 779, who found that insurers' examinations were part of the insurer's loss control efforts and were thus akin to investigation or surveillance. In considering the appeal, Mr. Justice Mandel

referred to the Arbitration decision of Mr. Justice Holland in *Jevco Insurance Company v. Guarantee Company of North America*, where Mr. Justice Holland had determined that administrative expenses, such as adjuster's fees, investigation expenses and surveillance expenses, are not subject to loss transfer. Mr. Justice Holland found that Section 275 of the *Insurance Act* was intended to restrict the right of indemnity to no-fault payments actually made and was not intended to expand the right of indemnity to the recovery of the first party insurer's administration costs, including the costs of their own medical assessments. The decision of Mr. Justice Holland was appealed to the Ontario Court (General Division) and by Order made July 29, 1994, Mr. Justice Moldaver dismissed the appeal.

In *Allstate v. Axa Boreal*, (1999) Arbitrator Robinson ordered reimbursement for expenses related to an insurer's examination, holding that the intent of the Legislation was that all payments made by the first party insurer should be reimbursed by the second party insurer except where it involved direct overhead, office overhead, adjuster overhead and such items as surveillance.

In *State Farm v. ING Insurance Company*, (February 16, 2005) a decision of Arbitrator Craig Brown, the question was whether payments for independent medical examinations or DAC reports were recoverable loss transfer expenses. Arbitrator Brown relied upon the decision in of Mr. Justice Mandel in *Jevco v. Prudential*

Insurance, (above) and concluded that the costs of independent medical examinations were a loss control measure and therefore not reimbursable. Arbitrator Brown noted that Bulletin A-11/94 was not law and could not change the law, and noted further that the *Insurance Act* had not been modified in any way following either Bulletin No. A-11/94 or the decision in *Jevco Insurance Company v. Prudential Insurance Company* (referred to above). He held, therefore, that there was no intent to change the original legislative purpose of limiting indemnity to statutory accident benefits. Arbitrator Brown was requested to opine as to whether the outcome would be different under the amended regulations relating to insurer examinations and DAC assessments which came into effect in 2003. Arbitrator Brown stated that he did not believe that the outcome would change, stating "until Section 275 is changed or the regulations are changed again to manifest an intention to include expenses for these measures and the indemnification entitlement, the decision in *Jevco* will continue to govern".

This approach (that indemnity is limited to the statutory accident benefits paid to insured) has also been adopted by Arbitrator Malach in two separate decisions. In *Progressive Casualty Insurance Company v. Markel Insurance Company of Canada* Arbitrator Malach dealt with the issue of recovery of case management services and occupational therapy services from an accident which occurred on January 14, 1992. Arbitrator

Malach confirmed that loss transfer indemnification was related only to the statutory accident benefits paid to the insured, making reference to the *Jevco Insurance Company v. Prudential Insurance Company* and the *Jevco Insurance Company v.. Guarantee Company of North America* decisions referred to above.

In *Certas Direct Insurance Company v. Allstate Insurance Company*, Arbitrator Malach dealt with the issue of recoverability of the cost of FSCO mediation and arbitration fees paid by the insurer arising from an accident that occurred on February 1, 2003. Arbitrator Malach found that recovery was limited to statutory accident benefits. He further noted that an insurer handling a claim for benefits will incur expenses for insurance examinations, assessments imposed by FSCO, surveillance, salaries, adjusting expenses, etc., but the legislation does not provide for recovery of such expenses.

In the decision of *Liberty Mutual Insurance Company v.. Zurich Insurance Company* (August 23, 2005), Arbitrator Guy Jones, while agreeing that the costs of insurer's medical examinations were not recoverable, held that the costs of DAC expenses were recoverable under the loss transfer provisions of the *Insurance Act* as they were "... designed, among other things, to determine what kind of treatment, if any, the insured person should have."

In October of 2007, Arbitrator K. Bialkowski, in the decision of *Motors Insurance v. State Farm Mutual Automobile Insurance*

Company, rejected the findings of both Arbitrator Bruce Robinson in *Allstate v. Axa Boreal*, (1999) and Arbitrator Guy Jones in *Liberty Mutual Insurance Company v.. Zurich Insurance Company*, (2005) in favour of the decisions of Mr. Justice Holland, Mr. Justice Modaver, Mr. Justice Mandel and Arbitrator Malach referred to above, noting:

"... the enabling legislation remains restrictive to amounts paid to the insureds. Motors (Insurance) further argues that the change in legislation and the elimination of DACs effective March 1, 2006, is relevant to the issues in dispute. I cannot agree. As long as the wording of Section 275 of the *Insurance Act* remains as it is, only those benefits paid to the insured are recoverable by way of loss transfer. I am of the view that if the legislature had intended to allow further recovery of the costs of insurer examinations and DACs, Section 275 of the *Insurance Act* could have easily been amended to allow for "indemnification for such benefits paid to the insured and the costs incurred by the insurer for medical examinations and DACs". The legislature did not. "

It follows from the above decisions that punitive damage awards, special awards and interest expenses for failing to pay benefits in accordance with the time lines set out in the SABS, are also not recoverable.

REASONABLENESS/SETTLEMENTS:

The onus of establishing that a primary insurer has made any unreasonable payments rests with the second party insurer. (see *Jevco Insurance Company v. Guardian Insurance Company* (Arbitrator Mallach, August 28, 2000; upheld on appeal by Mr.

Justice Jennings, November 20, 2000). It has been held that the test that must be met by the second party insurer is a very high one. In *Progressive Casualty Insurance Company vs. Markel Insurance Company of Canada* (May 13, 1997), Arbitrator Mallach stated:

“Unless it is established that the primary insurer acted in bad faith or grossly mishandled the processing of the claims for benefits under the Statutory Accident Benefits Schedule, the insurer responsible to indemnify the primary insurer must indemnify the primary insurer for benefits paid to the insured person.”

In dealing with reimbursement of monies paid in a settlement with the insured by the primary insurer, Arbitrator Mallach went even further, stating (see *Dominion of Canada vs. Royal & Sun Alliance*, August 20, 2001):

“The second party insurer must prove that any settlement entered into is clearly and grossly unreasonable or that there was gross mismanagement or gross negligence in the handling of the claim (by the primary insurer)”

The above decisions were followed by Arbitrator Guy Jones in *Primum Insurance Company v. Aviva* (March, 2008). In that case Arbitrator Jones noted:

“With the benefit of hindsight, I believe that (the primary insurer) could have obtained updated medical reports prior to settling out the claim. Indeed, it would have been a wise thing for it to have done ... I cannot say, however, that the settlement was clearly and grossly unreasonable or that there was gross mismanagement or gross mishandling of the claim.”

LIMITATIONS:

While previously the limitation period for applying for arbitration to recover amounts under the loss transfer provisions of the *Insurance Act* was six years, since the introduction of the new Ontario *Limitations Act* in 2002, the limitation period is two years. The Ontario Court of Appeal has held that in the case of a statutory entitlement to reimbursement, such as for loss transfer, the limitation period begins to run on the date the primary insurer makes a payment to the insured person. The Court of Appeal has also held, however, that the applicable limitation period is a “rolling limitation period” and that the primary insurer has two years from each payment, in which to put the secondary insurer on notice that it wishes to appoint an arbitrator to dispute the issue of non-reimbursement. (See *State Farm Mutual Automobile Insurance Company v. Dominion of Canada General Insurance Company*, (2005) 79 O.R. (3d) 78; 205 O.A.C. 270 (2005) and the Ontario Superior Court decision in *Lloyd’s Underwriters v. The Dominion of Canada General Insurance Company*, (2008) 89 O.R. (3d) 509).

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