A Commentary on Liberty v. Fernandes

By Stephen Ross

On Sept. 6, 2006, the Ontario Court of Appeal rendered its decision in Liberty Mutual Insurance Company v. Fernandes (Docket #C44262).

At first blush, this appears to be a finding against the insurer's interest. The Court of Appeal dismissed the appeal and upheld the Motion Court Judge's ruling that an insurer does not have the right to initiate a Court proceeding to challenge a CAT DAC.

However, upon a careful read of the Court of Appeal's Reasons, it would appear all is not lost. In fact, quite to the contrary.

The Court analyzed the entire SABS dispute resolution process. In so doing, it gave particular meaning and emphasis not before placed on sections 281 and 268 of the Insurance Act.

In short, the Court concluded that an insurer does not require recourse to the courts to challenge a CAT DAC because it has the ability, consequent upon a failed mediation, to simply offer any amount it feels it is prepared to settle the case.

The onus then shifts to the insured to institute whichever dispute resolution mechanism it wishes (FSCO arbitration or Court action) to challenge the insurer's offer made consequent upon a failed mediation.

Analysis

As stated, the Court came to this conclusion on the basis of its interpretation of section 281(3) which reads as follows:

> Payment pending dispute resolution
>
> (3) Subject to subsection (4), if mediation fails, the insurer shall pay statutory accident benefits in accordance with the last offer of settlement that it had made before the failure until otherwise agreed by the parties or until otherwise ordered by a court, by an arbitrator acting under this Act or the Arbitration Act, 1991 , or by the Director. 1996, c. 21, s. 37.

At page 8, paragraph 16 of Liberty v. Fernandes, the Court of Appeal states:

> If mediation has been tried and failed, the insurer can revert to paying only what it was willing to settle for, until there is an agreement or an order directing a different amount.

As a practical matter, this is quite likely a better result, from an insurer's perspective, than having the ability to challenge a DAC by way of a Court determination.

In essence, the Court of Appeal has indicated that a DAC's findings are only binding pending a failed FSCO mediation, after which time an insurer is only required to pay in accordance with their last offer.

This interpretation accords with the plain wording of the legislation, and does give effect to the previously-understood operation by which only insureds could choose between Court action or arbitration. The Court takes this one step further in that, an insurer can make whatever offer it wants (subject to its duties of good faith and the consequences of its breach) consequent upon a failed mediation, shifting the onus to the insured to institute any proceedings.

The Fernandes case dealt with an insurer's right to challenge a catastrophic determination by a DAC. The Court accepted the parties' agreement that a catastrophic impairment designation is not a "pay pending resolution" provision. Consequently, section 281(3) and not section 281(4) was deemed to apply.

The practical distinction between those matters which fall within the ambit of section 281(3) and 281(4) will, I respectfully speculate, not be insignificant.

For those matters which are deemed to be "pay pending resolution", the Court has, by necessary implication, indicated that section 281(4) is the operative provision.

Section 281(4) reads as follows:

> (4) If a dispute involves a statutory accident benefit that the insurer is required to pay under subsection 268 (8) [pay pending dispute resolution provision] and no step authorized by subsection (1) [insured commences arbitration or court action] has been taken within 45 days after the day mediation failed, the insurer shall pay the insured in accordance with the last offer made by the insurer before the failure until otherwise agreed by the parties or until otherwise ordered by a court, by an arbitrator acting under this Act or the Arbitrations Act, 1991 , or by the Director. 1996, c. 21, s. 37.

Procedure - Pay Pending Dispute Benefits

Accordingly, for those matters where the pay pending resolution mechanism applies, it would appear the process will be as follows:

- The insurer denies a benefit. The DAC makes a determination which is presumably against the insurer's interest.
- The insurer files for mediation at FSCO.
- The FSCO mediation fails.
- The insurer makes a final offer "before the failure" which is recorded in the Report of Mediator.
- If the insured starts a Court action or FSCO arbitration within 45 days, the insurer presumably then must continue to pay the disputed benefits in accordance with the DAC pending the judicial resolution of the dispute.
- The benefits will be paid pursuant to the DAC finding, but there will be a live proceeding in which the merits can be determined, although the proceeding has been initiated by the insured.
- If the insured does not initiate a proceeding within the 45 days, on the 46th day, the insurer "shall pay the insured" in accordance with its last offer.
- At this point, the onus will be on the insured to either accept the amounts offered and now being paid or commence a proceeding (FSCO arbitration or Court action) to obtain the benefits of the DAC and/or (potentially) even higher benefits.

Procedure - Non-"Pay Pending" Benefits

This mechanism is to be compared to the procedure which presumably now applies with respect to benefits which are not "pay pending resolution" in nature. That mechanism, pursuant to the Fernandes decision is as follows:

- The insurer denies the benefit.
- The DAC makes a determination, presumably against the insurer's interest.
- The insurer files for mediation at FSCO.
- The mediation fails.
- The insurer makes an offer to settle "before the failure", and is thereafter required to pay in accordance with that offer.

- Presumably in the aftermath, the insured will challenge the insurer's offer (and new payment levels) via a Court action or a FSCO arbitration.

Pay Pending or Not Pay Pending

A great deal can turn on the determination of whether a particular benefit is a "pay pending resolution" provision-type benefit.

Presumably, those benefits whose dispute resolution language mirrors that of section 40 of the Bill 59 SABS will be considered by the Court to be not pay pending.

The operative language considered by the Court of Appeal in Fernandes is that which is set out in section 40(4) as follows:

> 40(4) The determination by the designated assessment centre is binding on the insured person and the insurer, subject to the determination of a dispute, in accordance with ss. 279 to 283 of the Insurance Act, relating to whether the impairment is a catastrophic impairment.

The operative language therein is: "binding on the insured person and the insurer, subject to the determination of a dispute".

Similar language is found in the attendant care internal dispute resolution provision at section 39(10), the operative parts of which read as follows:

> 39(10) The determination by a designated assessment centre is binding on the insured person and the insurer in respect of the attendant care benefit, subject to the determination of a dispute in accordance with ss. 279 to 283 of the Act.

Accordingly, it would appear that both an attendant care, and a catastrophic determination are subject to the mechanism outlined in section 281(3) as dictated by the Court of Appeal in Fernandes.

Conversely, section 37(5) which controls the "refusal or stoppage of income replacement, non-earner or caregiver benefits", contains the following language:

> 37(5) The insurer may dispute the obligation to pay a benefit in accordance with ss. 279 to 283 of the Act and, pending the resolution of the dispute, the insurer shall pay the benefit".

This appears to be the type of pay pending provision properly contemplated by section 268(8) and hence, section 281(4).

Pursuant to Fernandes, in order for an insured to truly obtain the benefit of the pay pending dispute resolution provision, as it relates to weekly benefits, the insured must commence a proceeding (FSCO arbitration or Court action) within 45 days after a failed mediation. That appears to be the only way an insured can preserve the pay pending DAC amount right through to the end of a judicial determination.

As stated, this option does not appear to be available with respect to either attendant care or a catastrophic determination.

It would appear that pursuant to and consistent with the Fernandes decision and section 281(3), an insurer is relieved of its obligation to pay the DAC amount for attendant care or those amounts required pursuant to a catastrophic determination by a DAC, once there has been a failed FSCO mediation and an offer made by the insurer.

In short, in our view, weekly benefits are governed by section 281(4) and requires the insured to commence proceedings within 45 days of a failed mediation to preserve the DAC pay pending amounts; whereas attendant care benefits and catastrophic designation dependent benefits amounts (i.e. housekeeping beyond 104 weeks) are governed by section 281(3) and permit an insurer to offer whatever amounts it is willing to settle for, shifting the onus on the insured to commence a proceeding to attempt to obtain any greater amount(s).

Obviously, the only issue litigated in Fernandes was the catastrophic determination and hence, all other conclusions contained herein are at present simply our views in light of the legislation and the Fernandes decision.

This analysis and the Fernandes decision consider the Bill 59 SABS as it read prior to the March 2006 (elimination of the DAC) amendments.