

# ONTARIO AUTOMOBILE CLAIMS PRIMER

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## 1. INTRODUCTION

When a car accident occurs in Ontario, an injured person may pursue two separate avenues of recovery:

- A tort action may be commenced against the at fault driver, seeking recovery of damages; and
- An application for accident benefits may be submitted to the injured person's insurer, seeking payment of various accident benefits.

As a result of the undertakings signed by most U.S. insurers, for Ontario accidents the third party liability limits of the U.S. insurer's policy are automatically increased to \$200,000(CDN). In addition, the U.S. insurer will potentially have liability over and above the \$200,000 limits for the plaintiff's legal costs and disbursements. Furthermore, U.S. insureds are entitled to accident benefits at the levels set out by the Ontario Statutory Accident Benefits Schedule (SABs).

### *Accidents Occurring on or after October 1, 2003*

There were significant changes in the Ontario legislation pertaining to motor vehicle accidents in 2003. This paper deals with the law as it applies to motor vehicle accidents in Ontario occurring on or after October 1, 2003.

## 2. TORT CLAIMS

### *Non-pecuniary general damages:*

Based on the provisions of the Ontario *Insurance Act*, claims for non-pecuniary general damages are subject to a verbal threshold and monetary deductible. The threshold for recovery of non-pecuniary damages is defined in section 267.1 of the Ontario *Insurance Act* as:

- (a) permanent serious disfigurement; or
- (b) permanent serious impairment of an important physical, mental or psychological function.

The serious and permanent threshold is further defined by regulation which also sets

out evidence that must be adduced to prove entitlement. “Serious” requires: “substantial interference with ability to continue with regular or usual employment despite reasonable accommodation...; or substantial interference with most of the usual activities of daily living considering the person’s age”. “Permanent” is of a nature that is expected to continue without substantial improvement when sustained by persons in similar circumstances.

In Canada, there is a cap on non-pecuniary general damages. As of 2017, that amount is set at \$368,946.

Pre-Judgment interest is calculated on general damages at 5% per annum. The *Insurance Act* was recently amended, resulting in a change in the calculation of pre-judgment interest on non-pecuniary damages from 5%, to a rate consistent with a rate set by the *Courts of Justice Act*, which will vary with inflation. Currently, for accidents occurring in the first quarter of 2017, the pre-judgment interest rate is 0.8%.

### *FLA Claims*

In addition to claims by injured persons, dependant relatives of persons injured or killed in accidents are entitled to claim for pecuniary losses and damages resulting from a loss of care, guidance and companionship of the injured or deceased persons. *Family Law Act* claims are reduced for contributory negligence attributable to the injured or deceased person.

Section 61 of the *Family Law Act* sets out the rights of dependants to sue in tort. It states in part:

If a person is injured or killed by the fault or neglect of another under circumstances where the person is entitled to recover damages, or would have been entitled if not killed, the spouse, as defined in Part III (Support Obligations), children, grandchildren, parents, grandparents, brothers and sisters of the person are entitled to recover their pecuniary loss resulting from the injury or death from the person from whom the person injured or killed is entitled to recover or would have been entitled if not killed, and to maintain an action for the purpose in a court of competent jurisdiction.

The damages recoverable by FLA claimants include:

- (a) actual expenses;
- (b) actual funeral expenses;

- (c) travel expenses in visiting the person during his or her treatment or recovery;
- (d) loss of income or the value of the nursing, housekeeping or other services provided for the person; and
- (e) compensation for the loss of guidance, care and companionship that the claimant might reasonably have expected to receive from the person if the injury or death had not occurred.

In certain dependency circumstances, FLA claimants may also be entitled to claim loss of financial support which would have been received from the injured or deceased person. FLA claimants may also be able to claim for their own income losses suffered because of the grief or upset sustained as a result of the death or serious injury of the main plaintiff (or estate).

#### *Non-Pecuniary Damages - Statutory Deductible:*

The statutory deductible applies only to non-pecuniary losses and is to be applied to the award of damages before any split in liability.

An injured plaintiff's award is to be reduced by statutory deductible. As of 2017, the deductible for an injured plaintiff is \$37,385.17, and applies to all non-pecuniary damages awards of less than \$124,616.21. This amount is indexed to inflation, and is updated annually.

Each *Family Law Act* plaintiff's award is to be reduced by a statutory deductible of \$18,692.59 on all awards of less than \$62,307.59 (also indexed to inflation).

There is no deductible for wrongful death claims, where the accident occurred after August 31, 2010.

#### *Pecuniary Losses*

Health care claims are permitted, but only if the plaintiff's injuries meet the serious and permanent threshold. This can be a significant source of exposure in serious injury cases, where the actual health care costs exceed available funding through collateral benefits (including SABS or private health care plans).

Claims for housekeeping and home maintenance/handyman expenses are common. Various other claims for special damages are permitted subject to remoteness.

Neither the threshold nor the deductible applies to other pecuniary loss claims.

There can be no claim for income losses suffered in first seven days after the accident. Claims for pre-trial income loss are restricted to 70% of gross income loss, for accidents that took place on or after September 1, 2010. Claims for post-trial income loss are assessed at 100% of gross income loss.

### ***OHIP Subrogated Claims***

In situations where the automobile liability policy is not written in Ontario, there may be further exposure to subrogated claims brought on behalf of Ontario Health Insurance Plan (OHIP) for health care expenses incurred in connection with the treatment of the injured person. Releases signed by plaintiffs do not bind OHIP in regards to potential subrogation, unless OHIP is aware of and agrees to the settlement reached.

### ***Collateral Benefits***

Collateral benefits are statutorily required to be deducted from economic losses in the context of a tort award, but are not to be deducted from non-pecuniary damage awards.

For income losses, based on the *Insurance Act* provisions, the plaintiff's damages are reduced by: all SABS received or available for income loss or loss of earning capacity up to date of trial; all payments received or available under a legislated income continuation plan or an income continuation benefit plan up to the date of trial (e.g. CPP Disability); and all payments received under a sick leave plan up to the date of trial.

Similar statutory provisions require that health care expenses and other economic loss claim awards be reduced by collateral benefits received or available up to the date of trial. A benefit is deemed not available if the plaintiff has made an application for the benefit in good faith, and the benefit has been denied.

However, after a trial, plaintiffs are entitled to recover future pecuniary losses from the tortfeasor without regard to future collateral benefits. Future benefits will be subject to a statutorily codified *Cox v. Carter* Order which requires the plaintiff to hold all future benefits received from collateral payors in trust for the tortfeasor. Alternatively, a court may order that the plaintiff assign future rights to collateral benefits over to the tortfeasor and to co-operate with the tortfeasor in the future collection of benefits from collateral payors.

### ***Direct Compensation Property Damage***

Section 263 of the Ontario *Insurance Act*, in essence provides that, in the event of a collision between two insured vehicles, each vehicle's insurer pays its own insured the

property damage that would ordinarily be the obligation of the other party's insurer.

As an example, if a U.S. vehicle were to collide with a vehicle, "X", insured by another insurer, and X was 75% at fault for the accident, the U.S. insurer would pay its insured 75% of the insured's property damage claim under the Direct Compensation Property Damage coverage.

If the U.S. insurer's insured carried collision coverage, the U.S. insurer would pay the remaining 25% under the collision coverage. Fault is determined by a Fault Chart in R.R.O. 1990, Reg. 668. These rules can be found at: [http://www.e-laws.gov.on.ca/html/regs/english/elaws\\_regs\\_900668\\_e.htm](http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900668_e.htm)

### 3. ACCIDENT BENEFIT CLAIMS

An insured person may claim SABS from his/her own personal insurer, employer's insurer, insurer of vehicle in which he/she is an occupant at the time of the accident, or insurer of other vehicles involved in the accident. Numerous different types of SABS benefits are available as part of the standard Ontario automobile policy depending on nature and severity of the claimants injuries.

There is, generally speaking, no ability for an insurer to subrogate to recover SABS payments made to its insureds. There are certain exceptions in claims involving certain classes of automobiles, including heavy commercial vehicles and motorcycles (referred to as "loss transfer" claims).

In addition to changing the rate for pre-judgment interest on non-pecuniary damages, Bill 15 also implements a change of the dispute resolution process for accident benefits claims. Previously, a claimant could apply to the Financial Services Commission of Ontario ("FSCO") for mediation. Bill 15 replaces FSCO mediation with a body called the Licence Appeal Tribunal ("LAT"). These new procedural provisions for resolution of statutory accident benefits disputes by the LAT have not yet been implemented.

#### *Weekly Benefits*

*Income Replacement Benefits:* compensate for lost income if claimant suffers a substantial inability to perform the essential tasks of his/her pre-accident job. Income replacement benefits are payable beyond two years after the accident if the claimant suffers a complete inability to engage in any employment for which he/she is reasonably suited by education, training or experience.

The benefit is calculated at 70% of gross income before the accident up to a maximum weekly benefit of \$400 (for accidents that took place after September 1, 2010).

*Non-Earner Benefits:* compensate if the claimant is completely unable to carry on a normal life, and does not qualify for an Income Replacement Benefit or Caregiver Benefit. The benefit is \$185 per week beginning 26 weeks after complete inability arose.

*Caregiver Benefits:* compensate the claimant for expenses incurred if he/she cannot continue as the main caregiver for a person (such as child under age 16) who needs care. The benefit pays expenses up to \$250 per week for the first person in need of care, plus \$50 for each additional person.

For accidents occurring after September 1, 2010, caregiver benefits are only available for claimants deemed to be catastrophically impaired.

### *Health Care Benefits*

*Medical Benefit:* pays for reasonable and necessary medical expenses incurred as a result of claimant's injuries, which are not covered by any other medical plan, such as the Ontario Health Plan, or any medical plans at the workplace.

*Rehabilitation Benefit:* pays for reasonable and necessary rehabilitation expenses incurred as a result of claimant's injuries. These are expenses that are not covered by any other plan.

*Attendant Care Benefit:* compensates for the expense of an aide or attendant or services provided by a long-term care facility at prescribed rates.

The maximum amount available for non-catastrophically impaired claimants for medical and rehabilitation expenses is \$50,000, with a 10 year time limit, and \$36,000 for attendant care benefits with a two year time limit. However, if the claimant is catastrophically impaired, the maximum amount is \$1,000,000 for medical and rehabilitation expenses, and \$1,000,000 for attendant care expenses, with no time limits.

*Other Expenses:* there is also coverage available for expenses of family members incurred when visiting you during treatment or recovery; housekeeping and home maintenance, payable at a maximum of \$100 per week, repair or replacement of items lost or damaged in the accident such as clothing, prescription eyewear, dentures, hearing aids, prostheses and medical or dental devices; lost educational expenses; and the reasonable cost of examinations obtained for the purposes of the *Statutory Accident Benefits Schedule*.

For accidents occurring after September 1, 2010, this benefit is only available for claimants deemed to be catastrophically impaired.

*Death and Funeral Benefits:* are available to pay family members of a person killed in an

automobile accident (\$25,000 is paid to a surviving spouse, \$10,000 to each surviving dependant, and a total of \$10,000 to a person on whom the deceased was a dependant) and up to \$6,000 to cover funeral expenses.

*Optional Benefits:* are available for purchase from Ontario insurers, which increase the limit of many of the benefits above.

As set out above, if the claimant meets the definition of “catastrophic impairment”, he/she is entitled to significantly increased accident benefits (monetary and temporal limits). “Catastrophic impairment” includes: paraplegia or quadriplegia, amputation or other impairment causing total and permanent loss of use of both arms or total and permanent loss of both an arm and leg or both legs, total loss of vision, certain brain injuries, and certain other combinations of impairments that result in 55% or more impairment of the whole person. This determination must be made by medical experts.

### ***Accident Benefits Procedures***

The SABS provides for a rather intricate procedural system for claiming and responding to claims for accident benefits, including numerous forms (OCFs) created by FSCO. The system involves rather strict timelines for responses to various forms submitted to insurers and involves the determination of entitlement based on the severity of the initial injury, followed by ongoing assessments. If treatment modalities or benefits being sought are not approved, entitlement may be determined by way of medical examinations and insurer’s assessments.

Various SABS sections require compliance by the insured with requests for information and documentation. Non-compliance (without a reasonable explanation) can result in suspension and/or forfeiture of benefits. Insurers are permitted to terminate IRBs, Non-Earner Benefits and Caregiver Benefits if insured fails to participate in treatment or seek reasonable employment. In addition to medical examinations, insurers may conduct an Examination under Oath of the claimant (with limitations).

### ***Accident Benefits Litigation***

Once Bill 15 is fully implemented and the Licence Appeals Tribunal becomes the governing body for dispute resolution, claimants will no longer have the option of commencing a court action for adjudication of accident benefits issues.

A court action for accident benefits is governed by the same *Rules of Civil Procedure* as a tort action.

Actions and arbitration proceedings claim specified benefits and declarations for entitlement to ongoing benefits. An insured cannot sue to compel a lump sum

settlement, but an insurer may elect to fully and finally resolve a claim.

There can be no lump sum settlements until one year after accident, unless there have already been examinations for discovery in a court action, there is a private arbitration agreement in place, or a FSCO pre-arbitration discussion has occurred. There are strict requirements with which insurers must comply regarding disclosure and settlement documentation when a claim is fully and finally settled.

### *Accident Benefits Claims Handling*

Due to the overly technical nature of Ontario SABs claims handling and the onerous timing restrictions, we highly recommend that an insurer retain a qualified adjuster to administer its first party accident benefits claims

## **4. PRIORITY AND LOSS TRANSFER DISPUTES**

Disputes between insurers regarding payment of accident benefits may arise in two different contexts and result in two distinct categories of disputes which must be resolved by way of private arbitration under the *Arbitrations Act, 1991* (which are distinct from FSCO arbitrations)

*Priority Disputes* arise in situations where an insurer disputes its obligation to pay accident benefits to a claimant and alleges that there is another insurer which stands in higher priority to pay those benefits.

*Loss Transfer* is a mechanism to re-allocate the burden of paying accident benefits in the context of accidents involving those vehicles which cause heavy losses (heavy commercial vehicles) and the most vulnerable vehicles (motorcycles).

The parties generally sign an Arbitration Agreement appointing a private arbitrator and outlining certain rules which governs the dispute, failing which they are governed by the default provisions in the *Insurance Act* and the *Arbitrations Act, 1991*. Recourse to the courts for Priority and Loss Transfer Disputes is only with respect to “initiating” an Arbitration in order to force the appointment of an arbitrator and force the respondent to submit to arbitration or with respect to appeals from private arbitrators’ awards.

### *Priority Disputes*

Priority disputes are disputes between insurers regarding the responsibility to pay accident benefits to a claimant. The dispute mechanism is set out in Regulation 283/95 of the *Insurance Act*. This mechanism provides an insurer with the ability to permanently transfer an accident benefits claimant to another insurer



The priority scheme detailing which insurer bears the responsibility to pay is set out in section 268 of the *Insurance Act*. Simply put, the hierarchy of priority for payment of accident benefits is as follows:

1. The insurer of an automobile in respect of which the claimant is a named insured or a spouse or dependant of a named insured
2. The insurer of an automobile in respect of which the claimant is an occupant
3. The insurer of an automobile involved in the incident from which entitlement to benefits arose

This hierarchy is complicated by certain definitions in the SABS and certain provisions in the SABS which can deem an individual to be a named insured in situations where a company vehicle is made available for his/her regular use or where there is a long-term rental. Specific priority issues arise in situations involving “dependency”, “marital status”, “occupancy”, “regular use provided by a corporation”, etc.

Early and thorough investigation of priority issues is essential.

The first insurer to receive a completed application for accident benefits must begin paying benefits pursuant to the SABS subject to a priority dispute. Within 90 days of receiving a completed application for accident benefits, an insurer must put all other potential insurers on notice of a priority dispute. The 90 day notice period may be extended only in certain narrow circumstances and if not satisfied is fatal to the dispute. Within one year of the first notice of priority dispute, a private arbitration proceeding must be initiated.

### *Loss Transfer Disputes*

Loss transfer disputes are a different type of dispute between insurers. The loss transfer mechanism provides an insurer with the ability to seek indemnity for benefits paid and expenses incurred in connection with an accident benefits claim, but the accident benefits claim will continue to be administered by the same insurer.

The loss transfer mechanism is set out in section 275 of the *Insurance Act* and Regulations 664 and 668. The insurer seeking the loss transfer is the “first party insurer” and the insurer against whom the claim is brought is the “second party insurer.” Loss transfer is generally available:

- to the insurer of a motorcycle from the insurer of any other class of automobile; and

- to the insurer of any other class of automobile from the insurer of a heavy commercial vehicle.

The rationale is that under a no-fault system, a shifting of the burden is required when greater loss causing and more vulnerable vehicles are involved in an accident.

It has been held by the Ontario Court of Appeal that, where a foreign insurer is a signatory of the Power of Attorney Undertaking, it is entitled to bring a loss transfer claim with respect to an accident in Ontario.

“Heavy commercial vehicle” is defined in section 9(1) of Regulation 664 as: a commercial vehicle with gross vehicle weight greater than 4,500 kg or approximately 10,000 lbs. According to the *Insurance Act* a “commercial vehicle” is an automobile used primarily to transport materials, goods, tools or equipment in connection with the insured's occupation.

Loss transfer indemnification is made according to the respective degree of fault of each insurer's insured. In an attempt to achieve expediency over exactitude, fault for the purpose of loss transfer is determined under the Fault Determination Rules in Regulation 668 (either 0%, 50% or 100%). If the accident is not described in any of the rules or there is insufficient information about the accident, fault is determined according to the “ordinary rules of law”. Indemnity is paid only to the extent that the second party insurer's insured was at fault for the accident

Section 275(2) provides the first party insurer with a right of indemnification “in relation to such benefits paid by it.” In the loss transfer context, administrative expenses such as adjusting fees, investigations, costs of insurer's examinations and other “loss control measures” are not recoverable from the second party insurer. Section 275(3) stipulates that there is no indemnity available in respect of the first \$2,000.00 of accident benefits paid (the deductible).

The second party insurer may also challenge the reasonableness of the payments made by the first party insurer, including whether the insured was reasonably entitled to payment of the benefits delivered by the first-party insurer. Generally, however, a second party insurer must prove gross negligence on the part of the first party insurer, in order to be successful on such a challenge. There is arguably no indemnity payable for overpayments of benefits and interest paid on overdue benefits.

It has been held that a lump sum settlement of the insured's past, present and future accident benefits constitutes the “payment of statutory accident benefits” and is, therefore, subject to loss transfer.

The Ontario Court of Appeal has held that the limitation period for loss transfer claims only arises once the first party insurer puts the second party insurer on notice of a claim, and the second party insurer refuses this demand for reimbursement, which is deemed to be refused one day after the demand.

Accordingly, the limitation period expires 2 years plus 1 day following the demand for loss transfer reimbursement. Please see: *Markel Insurance Company of Canada v. ING Insurance Company of Canada*, 2012 ONCA 2018.