IN THE MATTER OF THE *INSURANCE ACT*, R.S.O. 1990, c. I. 8 (as amended)
AND ONTARIO REGULATION 283/95 (as amended)

AND IN THE MATTER OF THE *ARBITRATION ACT*, S.O. 1991, c.17

AND IN THE MATTER OF AN ARBITRATION

BETWEEN:

UNIFUND ASSURANCE

Applicant

- and -

TRAVELERS INSURANCE COMPANY

Respondent

DECISION

COUNSEL

Derek Greenside – Kostyniuk & Greenside
Counsel for the Applicant, Unifund Insurance Company
(hereinafter referred to as "Unifund")

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Counsel for the Respondent, Travelers Insurance Company
(hereinafter referred to as "Travelers")

ISSUE – PRIORITY DISPUTE - INDEMNITY – REASONABLENESS OF PAYMENTS

[1] In the context of a priority dispute pursuant to s. 268 of the *Insurance Act, R.S.O. 1990, c. I.8,* and with Travelers having accepted priority, the issue remaining before me is to determine the extent to which Unifund is entitled to indemnity. This involves an analysis of the "reasonableness of the payments" made to or on behalf the claimant Joseph Sulkowski, with respect to personal injuries sustained in a motor vehicle accident which occurred on September 22, 2017.

PROCEEDINGS

[2] The matter proceeded on the basis of written submissions, document briefs and oral submissions made on September 15, 2020.

FACTUAL BACKDROP

[3] Josef Sulkowski (hereinafter "JS") was born on February 21, 1945. He would have been 72 years of age when he was rushing to catch a city bus, slipped and fell with resulting injury to his foot and leg when one of his lower extremities was run over by the bus which was unable to stop on September 22, 2017. The city bus was insured under automobile insurance policy 277JG5428 issued by Travelers Insurance Company of Canada.

[4] JS submitted his completed Application for Accident Benefits (OCF-1) to Unifund Assurance Company on November 1, 2017. Unifund insures one of his daughter's (Maya Sulkowski) vehicles. Unifund Assurance sent their Notice to Applicant of Dispute Between Insurers to JS and Travelers Insurance on January 30, 2018, on the basis that the claimant was not principally financially dependent on his daughter and therefore not an insured under the Unifund policy, alleging that Travelers was therefore the priority insurer.

[5] Unifund Assurance Company served Travelers Insurance with their Notice of Initiation of Arbitration and Demand to Appoint an Arbitrator on or about October 31, 2018 and the proposed Arbitrator accepted the appointment to act as Arbitrator on December 13, 2018.

[6] This priority Application has proceeded through numerous pre-arbitration hearing teleconferences. Respondent's counsel ultimately confirmed his instructions to concede priority but contest the quantum of indemnity sought by Unifund Assurance (specifically with respect to the Full and Final Settlement which was concluded on or about July 25, 2019) at the pre-arbitration hearing teleconference on January 16, 2020.

[7] The following summarizes the indemnity initially sought by Unifund Assurance from Travelers Insurance in this priority dispute:

Medical/Rehabilitation Prior to Full and Final Settlement	$ 80,595.77
Medical/Rehabilitation as Component of Full and Final Settlement	$ 300,000.00
Attendant Care Prior to Full and Final Settlement	$ 53,839.01
Attendant Care as Component of Full and Final Settlement	$ 340,000.00
Non-Earner Benefit Prior to Full and Final Settlement	$ 17,390.00
Non-Earner Benefit as Component of Full and Final Settlement	$ 1,295.00
Cost of Examinations	$ 23,139.11
Housekeeping/Home Maintenance	$ 20,000.00
Disbursements	$ 8,705.00

Total Indemnity Initially Sought from Travellers Insurance	$ 844,963.89

[8] A complete copy of the accident benefits claims file (six volumes) and additional records relating to the full and final settlement (two volumes), were provided to Respondent's counsel. These records contain the underlying OCF-6s, OCF-9s, OCF-18s and OCF-21s documenting the benefits and expenses paid by Unifund Assurance and now sought from Travelers Insurance.

[9] In the course of handling the underlying accident benefits claim, Unifund Assurance arranged to have JS catastrophically assessed by Dr. Edwin Urovitz (orthopedic surgeon) on August 8, 2018. At the time, JS reported constant daily pain in his left lower extremity and persistent swelling in his left foot. He was wheelchair dependent and his ability to stand was limited to approximately three minutes. He was unable to walk or weight bear on his left leg. Physical examination revealed 2 cms of atrophy in his left thigh and 1 cm of atrophy in his left calf. Examination of his left hip revealed reduced hip flexion and reduced internal and external rotation. Examination of his left knee revealed restricted mobility and extension. Examination of the left ankle revealed reduced dorsiflexion, plantar flexion and inversion/eversion and there was only a flicker of movement in his toes. There was approximately 5 cm of swelling in his left foot and his left foot, ankle and calf were tender to touch. JS attempted to transfer onto the examination table but was unable due to balance problems and significant pain when he attempted to weight bear on his left leg. In his corresponding report, Dr. Urovitz confirms that JS suffered a major degloving injury of the left lower extremity and multiple fractures including the first and second metatarsals, medial cuneiform, navicular, calcaneus and proximal tibiofibular joint. Dr. Urovitz concluded that JS was catastrophically injured under Criterion 2 of Section 3.1 of the Statutory Accident Benefits Schedule (severe and permanent alteration of prior structure and function involving his left leg resulting in severe impairment of ambulatory mobility).

[10] Unifund Assurance also arranged to have Dr. Urovitz provide them with an opinion concerning his entitlement to Non-Earner Benefits following the aforementioned assessment. In his corresponding report, Dr. Urovitz confirmed that JS is unable to participate in his pre-accident activities (housekeeping and home maintenance, feeding himself, dressing himself and grocery shopping) due to chronic pain in his left leg. Dr. Urovitz confirmed that JS was wheelchair-bound and that he sufferred a complete inability to carry on a normal life as a direct result of the motor vehicle accident.

[11] Unifund Assurance accepted the medical opinion of Dr. Urovitz that the claimant was catastrophically injured in the motor vehicle accident on September 22, 2017.

[12] As for pre-accident health, Mr. Sulkowski had a history of bipolar disorder (for which he was taking mediations), together with Obsessive Compulsive Disorder and hoarding tendencies. He also had left cataracts, GERD, Schatzki ring in, hiatus hernia, scoliosis and osteoporosis. He was on long-term disability and had not worked for several years. Other pre-existing medical conditions included skin cancer addressed in 1996. Travelers has

claimed that the effect of these medical issues were never canvassed or subject to a medical analysis of the effect on Mr. Sulkowski's life expectancy by Unifund. However, impairment rating was considered in the structure quotes obtained by Unifund from McKellars and Unifund also purchased a ten year reversionary guarantee of the amount, structured at a cost of $46,579.21, which Unifund concedes is not recoverable.

[13] As of mid-December 2018 – 15 months post-accident – Unifund had made the following payments to and/or on behalf of Mr. Sulkowski: (a) NEBs of $11,655; (b) medical and rehabilitation benefits of $29,627.64; and attendant care benefits of $31,002.62. Thereafter, a full and final settlement was settled seven months later in the amount of $670,000. This was 22 months post-accident. Mr. Sulkowski was 74.5 years old at the time his AB claim was settled on a full and final basis with Unifund in July 2019.

[14] JS was living in a convalescent home at the time the full and final settlement was concluded in July 2019. The convalescent home would have been responsible for cleaning his room and bathroom. According to Unifund, JS was not happy living in that environment and was eager to make alternative living arrangements, resulting in his incentive to settle his accident benefits file on a full and final basis.

[15] Travelers Insurance has not paid Unifund Assurance any of the indemnity claimed. Travelers claims that there was no reasonable basis to settle the underlying claim of JS on a CAT basis and that the amounts paid were grossly unreasonable.

[16] Travelers has obtained a report from Dr. Fern dated April 30, 2020, critical of Unifund's catastrophic determination; a report from Dr. Armstrong dated June 22, 2020, critical of Unifund's dealing with the life expectancy issue and; a report from Laurie Walker dated July 30, 2020, critical of Unifund's adjusting of the underlying AB claim of Mr. Sulkowski.

[17] The issue in dispute is "reasonableness of payments".

APPLICABLE JURISPRUDENCE

[18] The jurisprudence with respect the issue of "reasonableness of payments" in a priority dispute or a loss transfer dispute appears well settled.

[19] An insurer who resists full repayment of eligible benefits bears a heavy onus to establish the payments were not reasonable. Justice Stewart, having considered the onus in the context of loss transfer disputes, stated in *Jevco Insurance Company v. Gore Mutual Insurance Company, 2014 CarswellOnt 13474*:

> " The onus is a strict one, and the second party insurer must demonstrate that the first insurer either acted in bad faith or grossly

> mishandled the claim such that the amounts paid out that it is seeking to recover are grossly unreasonable."

[20] Arbitrator Samworth considered "reasonableness of payments" in *Commercial Union Assurance Company and Boreal Property and Casualty Company, 1998 CarswellOnt 7744,* and articulated her view that the inquiry be limited to confirming that the handling insurer did not:

> (1) act in bad faith;
> (2) make payments that were not covered under the Statutory Accident Benefits Schedule in existence at the time of loss, ie. pay for a weekly benefit when there was no such entitlement; or
> (3) in general, so negligently handle the claim that payments were made greatly in excess of that which the insured would have been entitled had the file been managed by a reasonable claims handler.

[21] In *Economical v. Echelon* (Arbitrator Samworth – December 7, 2017), Echelon challenged the reasonableness of payments in a priority dispute with Economical. Echelon did not dispute the quantum or eligibility of the benefits, but rather the proof of incurred or economic loss of the attendant care provider.

[22] Arbitrator Samworth found that the principles of reasonableness of payments utilized in loss transfer disputes were applicable to reimbursement in a priority dispute. She cited her own test in *Commercial Union* (supra), wherein challenges to the reasonableness of payments are limited to situations where the primary insurer (ie. Unifund): acted in bad faith; made payments not covered under the SABs where there was no entitlement; or grossly mishandled the file.

[23] As to the evidentiary standard borne by the second-party insurer, Arbitrator Samworth indicated that it needed to prove only on a balance of probabilities that there should be no reimbursement to the first party insurer.

[24] On the particular facts of *Economical v Echelon*, Arbitrator Samworth suggested the following three-stage process for considering the reasonableness of reimbursement in priority disputes:

> a) The first-party insurer who handled claim must prove that benefits were paid for which reimbursement is sought;

b) The second-party insurer resisting reimbursement must prove that the adjusting of the file meets the test of bad faith or gross mishandling in the processing of the claim; and

c) The second-party insurer resisting reimbursement must prove that, had the file been handled properly, the payments would then not have been made.

[25] Arbitrator Malach offered the following comments with respect to an allegation that payments had been made unreasonably in *Jevco Insurance Company and Guardian Insurance Company of Canada, 2000 CarswellOnt 9456:*

> " .... various Arbitrators, including myself, have concluded that the second party insurer may not second guess the primary insurer as to the benefits paid to an applicant. That is because the first party insurer has the responsibility to pay the benefits to an applicant. The benefits must be paid on a timely basis. The first party insurer must make decisions on-the-spot as to whether certain benefits ought to be paid."

[26] Arbitrator Malach considered the relationship between the handling insurer and insured person and the indemnifier's onus again in *Dominion of Canada General Insurance Company and Royal & SunAlliance Insurance Company of Canada*, offering the following observations:

> " This system of loss transfer is a reimbursement system. It is based on the premise that the first party insurer has a relationship with the insured person and must treat that person fairly. The first party insurer must handle claims under the SABS reasonably and properly and must comply with the timelines set out in the SABS. The first party insurer owes a duty to the insured person to act in good faith. First party claims are different than third-party claims. When considering a loss transfer claim, one must assume that the first party insurer has acted reasonably and properly throughout the process..... Largely because of the unique relationship between the first party insurer and an insured person in claims under the SABS, I conclude that there is a very high onus on the second party insurer to demonstrate that any settlement was not reasonable. The unique relationship between the first party insurer and the insured person is recognized in the various Bulletins clarifying the loss transfer mechanism. If the second party insurer is not to intervene, and is not to interfere, and may not dictate claims handling decisions, and should not second-guess, then that second party insurer must prove that any settlement entered into is clearly and grossly unreasonable or that there was a gross mismanagement or gross negligence in the handling of the claim."

[27] Arbitrator Malach also considered the onus of the indemnifying insurer again in *Progressive Casualty Insurance Company and Markel Insurance Company of Canada, 1997 CarswellOnt 7555*, stating:

> "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 the benefits paid to an insured person."

[28] The aforesaid cases clearly establish a heavy onus on a party disputing reasonableness of payments in a priority or loss transfer dispute. However, each case must be decided on its own facts and there are cases where payments have been found to be unreasonable.

[29] For example, in *Jevco Insurance Company and Gore Mutual Insurance Company (*Arbitrator Novick - August 17, 2020), made the following findings of fact:

- the insured person's claim was settled on a full and final basis on June 16, 2009 for the additional sum of $250,000.00, which consisted of $42,500.00 for medical benefits, $42,500.00 for rehabilitation benefits, $150,000.00 for income replacement benefits and $15,000.00 for costs;

- no Insurer Examinations were scheduled, to assess the insured person's entitlement to post 104 week IRBs, until more than seven years after the insured person's completed OCF-1 was submitted to Jevco Insurance;

- the insured person's lawyer had made repeated requests to Jevco Insurance for re-training assistance which the insurer ignored;

- the total amount paid by Jevco Insurance to the insured person for IRBs (including the full and final settlement) was $210,000.00;

- the four post-104 week IE assessors concluded that the insured person did not meet the "complete inability" test;

- the CAT IE assessors concluded that the insured person was not catastrophically impaired;

- the insured person had submitted less than $10,000.00 in treatment costs in the seven year interval post-dating the accident;

- Jevco Insurance had just over two years of exposure to further claims for treatment at the time the full and final settlement was concluded.

[30] Arbitrator Novick concluded that the insurer's handling of the full and final settlement reached the threshold of "gross mishandling". She concluded that the only reason the Jevco representative paid the large settlement number it did, was her awareness that the claim had been mishandled for years and faced a large award for interest and potentially a special award. The Decision was upheld on appeal by Stewart J. as reported at 2014 CarswellOnt 13474.

[31] Clearly, with respect to "reasonableness of payments" each case must be decided on its own facts, but the test is clearly a strict one with an onus on the second party insurer to show bad faith or gross mishandling of the underlying AB claim.

ANALYSIS AND FINDINGS

[32] The Respondent Travelers does not take issue with the legal principles set out in the jurisprudence highlighted above, but claims that what constitutes "bad faith" or "gross mishandling" within a priority dispute remains undeveloped.

[33] Travelers claims that even in the absence of bad faith or gross mishandling of the underlying AB claim, where there is deficient handling of the AB claim that resulted in an overpayment or inflated settlement (ie. when benefits are not paid in accordance with the provisions of the SABS), the second-party insurer should not be saddled with those errors, especially since in priority disputes it is expected that the second-party insurer reimburses 100% of the benefits paid (unlike in loss transfer disputes where there are arguments under the Fault Determination Rules that may mean the full amount of the benefits paid by the first insurer are not recoverable). This is especially true, according to Travelers, in catastrophic cases, where significant amounts are in dispute.

[34] Travelers takes the position that if the standard is as high as demonstrating bad faith or gross mishandling, there is no incentive for a first-party insurer (ie. Unifund) to act with due diligence in handling a file and resolving a matter where it is not the priority insurer and will ultimately not be on the hook for the amounts paid to the claimant in the underlying AB claim.

[35] Travelers maintained that given the manner in which the first party insurer can obligate a second party insurer in a priority dispute, the first party insurer must have a significant and meaningful obligation to the insurer that will ultimately stand in priority (and be

responsible for the payments made to the claimant) to act in the interests of the second-party insurer; that is to say, as a reasonable insurer would in the circumstances.

[36] Having reviewed the jurisprudence provided to me by the parties and having considered the arguments advanced by counsel, I cannot help but find that the legal test for determining "reasonableness of payments" is no different than that expressed in the cases that I have reviewed above. It remains a very strict test with little turning on the words used, whether it be "bad faith", "gross negligence", "gross mishandling" or "a very marked departure from the expected standard of behaviour of an insurer handling a SABS claim". I am not satisfied that the test be any lower for the very reasons expressed in those cases. Each case must be decided on its own facts.

[37] Travelers has acknowledged that the priority dispute regime, as a procedural framework to resolve disputes between insurers, is not meant to require perfect handling of AB claims. And this is not to suggest that second-guessing is the task. However, they claim that the first-party insurer should not be permitted to make errors that significantly affect the second-party insurer. The standard should be akin to one of, if not correctness, then of near perfection or enhanced reasonableness. The first party insurer should not be permitted to get away with meeting only the bare minimum expected of a reasonable insurer, but its conduct has to be held, again, to a more significant and meaningful standard.

[38] Travelers has stated that this is particularly so where the first party insurer chooses not to alert or involve the second-party insurer in settlement negotiations.

[39] Travelers further claims that while there is no requirement that Unifund ought to have notified Travelers of the potential or impending settlement, or that it ought to have obtained approval of the settlement, such notice and approval ought to be a requirement (or a consideration) when examining the reasonableness of a first-party insurer's handling. The point being that a first-party insurer must be obligated to act reasonably in settlement negotiations and not prejudice the potential priority insurer by an inflated settlement. That is, the first-party insurer should be held to a particularly high standard in situations where it chooses, at its own risk, not to advise or seek the consent of the potential (or actual) priority insurer.

[40] Consistent with the existing jurisprudence, I am satisfied that the first party insurer is under no obligation to involve the second party insurer in settlement discussions before priority has been decided. Nevertheless, I would encourage communication as between the insurers involved in a priority dispute before entering into a sizeable lump sum resolution of the underlying AB claim, as it would go a long way at avoiding "reasonableness of payment" disputes of the kind here. In *Jevco Insurance Co. v. Guardian Insurance Co. of Canada* (August 28, 2000, Arbitrator Malach), upheld on appeal by Justice Jennings, unreported, dated November 20, 2000), Justice Jennings stated within a loss transfer dispute that "it may well be better practice for a first party insurer, contemplating a lump sum settlement with its insured, to seek input from the second party insurer, if the circumstances permit." It has also been stated that, "dialogue between the first and second party insurers while the claim is

being handled by the first party insurer is to be encouraged...". However, in the absence of communication between insurers, the second party insurer is still provided with the protection of not being responsible for payments made in situations of gross mishandling leading to overpayment and for payments made not required by the SABS. The protection of the "reasonableness of payments" jurisprudence, as outlined above, remains.

[41] Travelers has claimed that the full and final settlement was premature, being done a mere 22 months post-accident and that the amounts paid over and above the non-CAT limits were unreasonable.

[42] In their submissions, Travelers have highlighted numerous excerpts from the medical brief suggestive of the fact that the claimant had made a good recovery and was continuing to improve as set out in the paragraphs to follow.

[43] Travelers concedes that Mr. Sulkowski's injuries were significant, but claim that they were of a "largely plastic surgical nature." His GCS score was 15 upon admission to Sunnybrook Hospital immediately following the accident. The ER physician, Dr. Cleghorn, noted there was extensive soft tissue damage, but that Mr. Sulkowski was otherwise hemodynamically stable complaining only of lower leg pain. Mr. Sulkowski had no chest pain or abdominal pain. The only injuries on primary surgery were extensive soft tissue degloving below the knee on the left leg and distal phalanx fractures of the left foot. He also had no vessel injuries; no hemothorax or pneumothorax; no free fluid; no free air; no solid organ injury in the abdomen; no pelvic injury; no thoracoabdominal fracture; and no arterial injury in the left lower leg.

[44] He suffered a degloving injury of the left lower extremity below the knee and multiple fractures of the left foot. He was admitted to the plastic surgery service and underwent various irrigation and debridement surgeries in September-October 2017. These surgeries proceeded without incident and were carried out for soft tissue reasons which, based on the medical records, were still healing and the scars were still remodeling. His fractures were treated non-operatively.

[45] In an orthopaedic discharge note from September 23, 2017 (the day following the accident), prepared by Dr. Lim, the final diagnosis was extensive left leg degloving injury with associated multiple undisplaced mid/hind foot fractures with undisplaced proximal fibular head fracture. After undergoing irrigation and debridement of the left first metatarsal fracture/leg wound – (performed in conjunction with plastic surgery), the orthopaedic plan was to return for plastic surgery for definitive measure in a soft tissue injury. Orthopaedics required no further operative intervention. Mr. Sulkowski's foot was placed in an air cast boot and he was to follow up with plastics in six weeks.

[46] Mr. Sulkowski was discharged from hospital on October 24, 2017 and then spent eight weeks at St. John's Rehab Hospital. He was then transferred to the Chartwell Lansing Retirement Home on February 8, 2018, where he remained until the settlement of his AB claim in July 2019.

[47] While in St. John's Rehab, on November 29, 2017, Michelle Diamond, a social worker from Functionability, reported that Mr. Sulkowski's healing was going well and he was weight bearing as tolerated. His immediate goals of standing and functional movement would translate into greater independence and safety in the community.

[48] On December 18, 2017, Dr. Tushinski confirmed that Mr. Sulkowski had been clinically determined ready for discharge by both plastic surgery and orthopaedics, with instructions to weight bear as tolerated. This was less than three months post-accident. Dr. Wasserstein, the treating plastic surgeon, had previously indicated on November 6, 2017, that Mr. Sulkowski had no weight bearing restrictions on his left foot. He could also wear ankle foot orthotics if needed.

[49] By January 29, 2018, the physiatrist, Dr. Kekosz, noted that Mr. Sulkowski was able to walk very short distances in the parallel bars, but he was primarily wheelchair dependent.

[50] Travelers has claimed that Mr. Sulkowski continued to improve. In a report dated March 25, 2019 (18 months post-accident), Sarah Wallace from Functionability prepared a Rehabilitation Assistant Progress Report noting that Mr. Sulkowski has been able to ambulate short distances within his suite without a gait aid.

[51] By April 28, 2019 (19 months post-accident), it was noted in a Physiotherapy Progress Report from Functionability, prepared by Elly Baker, that Mr. Sulkowski reported that he had reached approximately 60% of his pre-collision physical functioning at this point in time.

[52] Although there had been some improvement, the Insurer Assessments conducted by Dr. Urovitz in 2018 in response to the claim of Catastrophic Impairment and the claim for Non-Earner benefits, concluded that the claimant met Criterion 2 of Section 3.1 of the Statutory Accident Benefits Schedule, suffering from a severe and permanent alteration of prior structure and function involving his left leg, resulting in severe impairment of ambulatory mobility leaving him wheelchair-bound and suffering from a complete inability to carry on a normal life. With those reports in its possession, how can one expect an insurer to successfully argue that the claimant suffered non-catastrophic injuries? What would a FSCO or LAT adjudicator likely find if the insurer's own medical assessments actually supported the claims advanced by the claimant? Would a denial of CAT benefits expose Unifund to a special award? I believe the answers to be clear. Unifund had every right to accept the medical opinions that it was provided by its own assessors.

[53] An issue has been raised as to the timing of the assessments conducted by Unifund. Travelers has claimed that the CAT assessment was done far too soon following the accident. The accident occurred on September 22, 2017. The OCF-19 or CAT application authored by Dr. Kekosz, was dated March 12, 2018. The CAT application was based solely on Criterion 2 of Section 3.1 of the SABS, being that the claimant was suffering from a severe and permanent alteration of prior structure and function involving his left leg resulting

in severe impairment of ambulatory mobility. Unifund was obligated to respond to the application in a timely fashion.

[54] After receiving the OCF-19, Unifund commissioned a file review report by the orthopaedic surgeon, Dr. Paitich, which was dated May 17, 2018. This was eight months post-accident. Dr. Paitich noted that Criterion 2 "stipulates that the alteration in prior function must be permanent prior to the evaluation" and that it was "clear to [him – Dr. Paitich] based on the injuries sustained, that permanent alteration of prior function has not yet occurred. Consequently, it would be premature to go forth with a catastrophic impairment evaluation in my view. When such an evaluation is undertaken (this should occur between 18 months and two years after the date of the injury)..."

[55] Dr. Paitich also noted that it would be important to have available all clinical notes and records from the treating orthopaedic surgeon and plastic surgeon, and the clinical notes and records and radiographic reports from the treating institutions.

[56] The concerns raised by Dr. Paitich with too early an assessment of Mr. Sulkowski's injuries, of course, is that such an assessment would not properly consider whether Mr. Sulkowski's injuries met the definition of catastrophic impairment under the SABS. Put another way, the worry was that Mr. Sulkowski could be found to have suffered catastrophic injuries if an assessment were conducted when his injuries were not yet permanent, and thus a false finding could be reported.

[57] Despite the comments of Dr. Paitich, Unifund obtained a CAT report from the orthopaedic surgeon, Dr. Urovitz, four months later on September 6, 2018. This was based on a one hour assessment by Dr. Urovitz, conducted on August 8, 2018. Dr. Urovitz was only asked to consider whether Mr. Sulkowski suffered a catastrophic impairment as set out in Criterion 2 – Severe Impairment of ambulatory mobility. Dr. Urovitz felt that Mr. Sulkowski did suffer a catastrophic impairment as a direct result of the accident. Again, Unifund did not commission a complete multi-disciplinary catastrophic assessment that would include an assessment of his physical (orthopaedic, plastic surgery, OT) and psychological injuries and impairments under any other sections of the SABS (ie. subsection 6-8 of section 3.1) in order to properly and fully canvass Mr. Sulkowski's injuries.

[58] Travelers claims that Dr. Urovitz did not consider the potential benefit of follow up treatment with a plastic surgeon, or potentially an orthopedic surgeon, to determine if anything further could be done to assist Mr. Sulkowski's ongoing recovery. Mr. Sulkowski had been discharged by orthopaedics on September 23, 2017 and by plastics in December 2017. No follow up x-rays were suggested, nor a bone scan or MRI, nor whether a chronic assessment or nerve block or other treatment modalities may be of benefit. At that time of Dr. Urovitz's assessment, Mr. Sulkowski was not receiving any physiotherapy. Dr. Urovitz noted that Mr. Sulkowski was "essentially" wheelchair bound. As mentioned, Travelers has obtained a report from the orthopaedic surgeon, Dr. Ken Fern, who has significant experience in catastrophic assessments. Dr. Fern was of the opinion that Mr. Sulkowski's AB

claim was at too early a stage to settle, and that Mr. Sulkowski could have improved with additional time. According to Dr. Fern:

> ...it would be my opinion that a catastrophic impairment was carried out sooner than what would be indicated, as I would not consider the stability criteria to have been met, that Mr. Sulkowski had made maximal medical recovery. He did sustain a significant crush injury, in which he had multiple fractures. It is noted the main injuries were noted to be more soft tissue in nature, requiring multiple surgical procedures through the Plastic Surgical Service. With regards to determining a catastrophic evaluation, it is preferable to carry out an impairment in which a percentage score can be attributed to the physical impairment based on measurable impairments. This would typically require assessing impairments with respect to loss of range of motion in various joints involved. The muscle atrophy, loss of strength and sensation are also impairments that can be rated. Problems with leg lengths and diagnosis-based estimates of impairment can also be used. A gait derangement methodology can also be carried out. However, it is typically felt to be more appropriate to use the most detailed calculation possible to determine whole person impairment. If an amputation occurs, involving an entire leg, the whole person impairment is calculated as being 40%, which in an of itself would not reach the catastrophic impairment criteria that is mandated in the SABS, which is 55%. Whole person impairment would typically also involve calculating the psychological impairments, among others.
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> In reviewing the records, I would consider that Mr. Sulkowski did sustain an obviously significant injury to his left lower leg. However, the more significant the injury, the longer timeframe in which the recovery will take. In my opinion as an orthopaedic surgeon, a chronic pain specialist and as a certified medical evaluator with specific training in carrying out catastrophic impairments, I would consider a formal calculation of catastrophic impairment would have required more time to have passed before maximal medical recovery would have occurred. Mr. Sulkowski's surgeries were carried out for soft tissue reasons which, based on the records, were still healing and the scars were still remodeling at the time of his assessment. I would defer to a plastic surgeon to comment on the impact on what would be considered skin and soft tissues disorders. However, it would be my opinion that his soft tissues had not yet fully healed and remodeled to allow for a catastrophic impairment evaluation of that to be carried out at the time in which it was done by Dr. Urovitz.
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> ...
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> I would be in agreement with the original catastrophic file review of Dr. Paitich, that a catastrophic impairment determination done at that time would have been premature, as the stability criteria for determining catastrophic impairment would not have been met. As such, in my opinion the use of criterion 2 would have been inappropriate. An up-to-date evaluation would be indicated to determine if a more detailed and specific measure of impairment, using the American Medical Association Guides to the Evaluation of Permanent Impairment. This will require formal functional testing, again when the stability criteria are met.

[59] The import of Dr. Fern's opinion and conclusion is that Mr. Sulkowski's injuries were not yet stable enough and he had not yet reached maximum medical recovery, such that the catastrophic assessment done by Unifund was premature, and that a different outcome was probable if a (complete) catastrophic examination had been conducted at a later (and proper)

time. That is, Mr. Sulkowski may not have suffered catastrophic injuries. Therefore, it is probable that Unifund paid benefits to which Mr. Sulkowski was not entitled under the SABS.

[60] More than that however, Dr. Fern faulted Unifund's decision only to proceed with an assessment under Criterion 2 of Section 3 of the SABS was improper and inappropriate.

[61] Ms. Walker was of a similar opinion as Dr. Fern. As noted by Ms. Walker in her report dated July 30, 2020, in referring the question of catastrophic impairment to Dr. Urovitz and the permanence of Mr. Sulkowski's injuries, "at no time did Unifund Assurance inquire if this was in fact, permanent, or if the continued rehabilitation would improve functionality." As to Unifund's process, Ms. Walker opined:

> In my view this determination process was premature and ignores both the recommendations by Dr. Paitich but also the criteria set out under Section 3.1 (2)(a) & (b)(ii). The insured continues to transition between residences and rehabilitation throughout these first months and adapting to his function was being introduced as reported in the Functionability Progress Report #1 dated June 1, 2018 prepared by Belsky Ng, OT. Further, physiotherapy only commenced in March 2018 with approval of funding to Balance Physiotherapy. The first Progress Report is dated September 29, 2018, more than 1 years from the accident and it is reported that the claimant was now only stable enough to commence a rehabilitation program that may have shown improvement.

[62] There is no doubt that timing of the assessment was an issue, but Unifund was also faced with an obligation to respond in a timely fashion, which it did in arranging the assessment with Dr. Urovitz. What appears lost in all of this is the fact that Dr. Urovitz always had the option of concluding that it was too early to conclude that the claimant's mobility impairments were permanent. He had in his possession the report of Dr. Paitich, dated May 17, 2018, which noted the concerns about the timing of an assessment of mobility. Had he concluded that any such assessment was premature, Unifund might well have avoided any exposure to a special award for not responding to the CAT application in a timely fashion. Instead, Dr. Urovitz was satisfied on the basis of the available medical records and his physical assessment of the claimant, that the left leg injury had resulted in a permanent and severe impairment of mobility satisfying Criterion 2 of Section 3.1 of the SABS. One can only conclude that any anticipated improvement was never going to change the claimant's severe impairment of mobility. Of utmost importance is the conclusion set out at page 7 of his report of September 6, 2018, that the limitations were "severe and permanent". Again, what is an insurer expected to do when in receipt of a report such as Dr. Urovitz's concluding that the claimant met the test for Catastrophic Impairment? Again and as I have indicated, if Dr. Urovitz felt that there was a reasonable prospect of further improvement that would have taken the claimant outside the range of Section 2 limitations, he could well have concluded that the assessment was premature. It must be kept in mind that the claimant suffered a major degloving injury and multiple fractures including fractures of the first and second metatarsals, medial cuneiform, navicular, calcaneus and fracture of the proximal tibiofibular joint. At the time of examination, he could not walk or weight bear on his left leg. His standing tolerance was limited to perhaps three minutes. He was wheelchair dependent. It is clear to

me that this is the type of injury and permanent limitation for which enhanced CAT benefits were contemplated. Given the conclusions reached by Dr. Urovitz, it would be most difficult for Unifund to have mounted a challenge of the CAT application. I have no difficulty in agreeing with Unifund's determination that the claimant was catastrophically injured in the subject motor vehicle accident given the findings of its own assessor.

[63] I must now address the issue of the amounts paid by Unifund as part of the full and final settlement on July 29, 2019. Having made the determination that the claimant had sustained catastrophic injuries, Unifund obtained a structure quote from McKellar, which is a structured settlement consulting firm regularly used by most automobile insurers in the province. The annuity quotes provided by McKellar for future medical and rehabilitation benefits was $243,086 and $382,036 for attendant care benefits.

[64] A review of the materials provided to me indicated that the adjuster for Unifund requested settlement authority for $640,000 for medical and rehabilitation benefits, representing a 10% reduction off the annuity quote for attendant care and 15% off of the structure quote, and also included an additional amount of $100,000 for home modifications.

[65] The full and final settlement executed on July 29, 2019, included payment of $670,000, broken down in the SDN as follows:

- $1,295 for NEBs
- $100,000 for medical benefits (home modificaitons)
- $200,000 for rehabilitation benefits
- $340,000 for attendant care benefits
- $20,000 for housekeeping benefits
- $8,705 for other benefits, which appears to be disbursements

[66] As a term of the settlement, it was agreed that $469,000 of the settlement funds would be structured with a 10 year reversionary guarantee to the benefit of Unifund. The cost of obtaining this reversionary guarantee was $46,579.21. Unifund has conceded that such is not an amount that can be ordered indemnified in this proceeding.

[67] Travelers further claimed that the payments made by Unifund were grossly unreasonable as they failed to consider the claimant's reduced life expectancy, which resulted in an overpayment of more than $300,000 in attendant care and medical/rehab benefits.

[68] Mr. Sulkowski was 72 years old at the time of the accident (born February 21, 1945). He has a history of bipolar disorder together with Obsessive Compulsive Disorder ("OCD") and hoarding tendencies. Other pre-existing medical conditions include skin cancer and osteoporosis. Travelers has claimed that these issues were never canvassed or subject to a

medical analysis by Unifund. Unifund did not take the basic step of determining the impact of Mr. Sulkowski's pre-existing medical issues and his accident-related injuries on his life expectancy.

[69] Support for Travelers' position is found in the claims handling expert report of Ms. Walker, dated July 30, 2020, where she indicated that "it is a reasonable and usual practice of an insurer to seek out impairment ratings and life expectancy considerations when attempting to "cash out" or settle a file where Catastrophic impairment and age limitations are present."

[70] In his June 22, 2020 report analyzing the life expectancy of Mr. Sulkowski as obtained by Travelers, Dr. Armstrong noted that Mr. Sulkowski was currently 75.3 years old and would have a normal life expectancy of approximately 10.8 years. Dr. Armstrong opined that Mr. Sulkowski's accident-related injuries would increase his mortality to three times that of an average man his age; that is, reducing his life expectancy (from 10.8 years) to 5.9 years. From the date of the accident, he would have had a normal life expectancy of 12.4 years, which would be reduced to 7.7 years. As Mr. Sulkowski was 72 years old at the time of the accident on September 22, 2017 (born February 21, 1945), he could be expected to live to age 79.7.

[71] A review of the claim documents reveal that Unifund instructed McKellar to use the residual amount of $913,661.68 that remained of the $1M limits to provide an annuity quote for future medical and rehabilitation benefits and attendant care benefits. It was not specifically advised to use a reduced life expectancy. McKellar assumed a rate of $3,000 per month for two years, then $1,500 per month thereafter. The annuity quote was $243,086. According to Travelers, using these amounts over the 5.2 years of Mr. Sulkowski's remaining life expectancy from the time of the full and final settlement, would amount to $129,000. Thus, Unifund "overpaid" by around $171,000 ($300,000 less $129,000) to settle the medical and rehabilitation component of Ms. Sulkowski's AB claim. As to the attendant care benefits, a Form-1 dated January 30, 2018 recommends monthly attendant care of $3,201.67. This amount is what Unifund recommended to McKellar to use to provide annuity quotes. According to Travelers, taking into account the reduced life expectancy and keeping with this amount, Unifund overpaid by $142,000 ($340,000 less $198,000 (5.2 years at $3,201.67)) on the attendant care component of the claim. Therefore the overpayment, according to Travelers, was over $300,000.

[72] A careful review of the claimant's pre-accident medical records reveals some pre-accident medical history as one might expect with any 72 year-old. Mr. Sulkowski's skin cancer (Leiomyosarcoma) was excised from his left chest wall with a skin graft in 1997. There is no evidence, in any of the medical records, to suggest that Mr. Sulkowski experienced a reoccurrence of skin cancer any time thereafter. Furthermore, the Sunnybrook Hospital records confirm that Mr. Sulkowski had a pre-existing bipolar disorder, had never been manic, had never been hospitalized, had never attempted suicide and had been stable on medication for many years prior to his involvement in the motor vehicle accident. His other ailments such as cataracts, GERD, hernia, scoliosis and osteoporosis are not health

problems that jump out as affecting life expectancy. With this medical information at hand, I would think that there was very little from the claim handler's perspective that cried out for a detailed life expectancy analysis. It is not that Unifund disregarded the life expectancy issue. In my view, they appropriately asked McKellar to determine if the structure costs might be improved with any impairment rating. To that end, the full medical brief was forwarded to McKellar. McKellar's communications with the life insurers approached indicated that none were in a position to provide an impairment rating. I take from that that there was nothing to suggest his skin cancer back in 1997 might return and that the claimant's bi-polar condition was well controlled with medication. In any event, if Unifund did obtain a specific life expectancy report, claimant's counsel would likely have obtained their own with opinions similar to the life insurers approached by McKellar.

[73] Despite the information obtained from the life insurers that they could not provide an impairment rating, Unifund nevertheless proceeded to purchase, at its own expense, a 10 year reversionary guarantee at a cost of $46,579.21. Unifund concedes this expenditure is not recoverable in this priority dispute proceeding and confirms that it will be assigned to Travelers. Given the pre-accident medical history, I am satisfied that by seeking an impairment rating and purchasing a 10 year reversionary guarantee of the structured amount, Unifund has reasonably dealt with the life expectancy issue on the facts of this case.

[74] Travelers also claims that Unifund was unreasonable in not completing a timely attendant care assessment prior to completing a full and final settlement. According to Travelers, a more timely assessment would probably have resulted in a lower monthly need.

[75] By way of background, a Form-1 was initially submitted on October 6, 2017, in the monthly amount of $9,002.78. This was while Mr. Sulkowski was an in-patient in Sunnybrook Hospital. Unifund denied this amount as being unreasonable and outdated and instead agreed to pay up to $3,201.67 per month, based on the Form-1 completed by Ng Belsky and submitted on January 30, 2018. This is just over three months post-accident, by which time Mr. Sulkowski's monthly attendant care needs had decreased noticeably as one might expect. At this time, Mr. Sulkowski was living at St. Hilda's Convalescent Care. This was only four months post-accident. Interestingly, 1,260 minutes of assistance was recommended under Level 1 care for "supervises/assists" in walking (rather than transferring from a wheelchair). As well, no Level 2 Basis Supervisory Care was recommended and specifically, it was determined that Mr. Sulkowski was independently able to get in and out of a wheelchair and/or to be self-sufficient in an emergency. It was reported by Mr. Sulkowski that he was independent with all his transfers from his wheelchair and was able to ambulate short distances with a walker with supervision.

[76] Prior to the full and final settlement negotiations in mid-2019, Unifund did not reassess Mr. Sulkowski's attendant care needs. This was despite the fact that over 1.5 years had elapsed since the last Form-1 was completed by Ms. Belsky in January 2018.

[77] Travelers claims handling expert Ms. Walker, in her report of July 30, 2020, noted that "given a lifetime exposure of a monthly benefit, along with all of the adaptive features that were provided and the improved function in activities of daily living, it is irregular that this benefit [attendant care] would not be reviewed." In Ms. Walker's opinion, the failure to reassess Mr. Sulkowski's attendant care needs was a "gross neglect of benefit review." According to Ms. Walker, "following rehabilitation, assistive devices and the change in surroundings, it is evident that the amount of benefit would most certainly reflect a different calculation." It is again probable, given Mr. Sulkowski's continued recovery, that an updated assessment would have resulted in a decreased monthly attendant care recommendation. Additional support is found in Dr. Fern's opinion, expressed in the orthopaedic report obtained by Travelers, that Mr. Sulkowski's injuries were not yet stable enough and had not yet reached maximum medical recovery as of May 2017.

[78] Unifund's claim handling conduct must be viewed on the basis of the medical documentation in its possession at the time of settlement. A careful review of the medical records would indicate that not much had changed in attendant care needs since the time of Ms. Belsky's assessment in January 2018. The claimant was an individual largely confined to a wheelchair in January 2018 and continued to be at the time of the settlement in July 2019. The medical report authored by Dr. Veronica Kekosz (physiatrist at Sunnybrook Health Sciences Centre), dated January 29, 2018, which accompanied the OCF-19, confirms her opinion that Mr. Sulkowski more than likely suffered a catastrophic injury which would affect his ability to ambulate for the rest of his life. She further opined that he may never be a functional walker and would be primarily wheelchair dependent with some abilities to perform transfers and minimal ambulation. Mr. Sulkowski attempted to ambulate with a walker but was off-balance and totally unstable. The responding report obtained by Unifund, authored by Dr. Urovitz, dated September 6, 2018, essentially came to the same conclusions. Not only did Dr. Urovitz confirm the functional limitations being experienced by the claimant, but confirmed that the limitations were both severe and most importantly, permanent. Being essentially wheelchair bound, he was in need of assistance in the long term. Mr. Sulkowski was followed by rehabilitation therapist Sarah Wallace between November 2018 and March 2019 and she confirmed in her Progress Report, dated March 25, 2019, that he had made minimal gains and required considerable assistance to complete his day to day tasks.

[79] Unifund cannot be criticized for accepting the opinions of the experts retained by them. Had Unifund rejected the medical opinion of their own expert, they would likely be addressing a successful claim for bad faith and a special award. The assessment of attendant care needs for a wheelchair bound individual was the same in 2018 as it was in 2019. I do not see Unifund's acceptance of the attendant care assessment as being grossly unreasonable.

[80] Travelers is also critical of Unifund's resolution of the medical and rehabilitation portion of the settlement. Its claims handling expert Ms. Walker opined that the settlement was achieved with no validation effort to determine what was reasonable and necessary and whether the claimant had achieved maximum medical recovery. Once again, Unifund's own

expert, Dr. Urovitz, had concluded that the claimant's situation was permanent. At the time of the final settlement, the claimant was residing at the Chartwell Retirement Residence. Unifund assumed that he would not be returning to his pre-accident accommodation, but was faced with a home modification claim that nevertheless had to be addressed. Unifund had been served with an OCF-18 by the claimant for a housing assessment. The Applicant arranged to have Adapt-Able Design Group prepare a Home Accessibility Report for the purpose of providing recommendations concerning necessary home modifications. Jeffrey Baum completed that assessment and concluded that the preliminary budget for construction, disability specific features (elevator, accessible kitchen and laundry, security system and stove guard) and associated expenses, was $508,509.00, including HST. As part of the final settlement, Unifund paid $300,000 towards its exposure to medical and rehabilitation benefits, inclusive of its exposure to the home modification claim. I am satisfied that the costs associated with Mr. Sulkowski's permanent accommodation at the Chartwell Retirement Residence translates to an amount which is far less than the costs associated with separate attendant care and home accommodation expenses. There is simply no basis for the assertion that such settlement was grossly unreasonable.

[81] Travelers had also claimed that the attendant care settlement amount failed to carve out the food costs portion of Chartwell's monthly fee, as that did not relate to attendant care. That is so, but the overall settlement of med/rehab benefits must be looked at in terms of the exposure to which Unifund was faced. They were looking at a home modification exposure in excess of $500,000, responsibility for ongoing treatment costs and exposure to a lifetime of attendant care needs for a wheelchair bound individual. McKellar's structure quotes did not include any component for home modifications. I am satisfied that the amount paid in total for med/rehab, attendant care and home modifications cannot be said to have been grossly unreasonable in the face of the combined exposures that Unifund faced. Whether they paid more for attendant care by not subtracting the food portion of Chartwell's monthly fee, but paid less for home modifications, should not matter when the totality of the payment in face of exposures cannot be said to have been grossly unreasonable. There is simply no indication that Unifund overpaid just to close a file.

[82] Another component of the final settlement criticized by Travelers was a $20,000 payment for housekeeping. Travelers claims that the amount was "not incurred" as required by the applicable legislation and that there was a housekeeping component to the monthly fee of $2,744 charged by Chartwell, for which the claimant received three meals per day and some housekeeping and laundry of bedding and clothes. Unifund maintains that there is no "incurred" requirement as the payment was for future services. However, I was unable to find any evidence of payments for additional housekeeping over and above that provided by Chartwell in the months leading up to the settlement. Furthermore, Unifund failed to conduct any assessment of housekeeping needs over and above that provided by Chartwell. Therefore, there is no basis to conclude that there would be future need given Unifund's theory of the med/rehab settlement wherein it was assumed that he would remain at Chartwell, rather than having his pre-accident accommodation modified. In the absence of any evidence, I find the payment grossly unreasonable and not subject to indemnification.

[83] Travelers also claimed that Unifund paid an amount for Non-earner benefits in excess of the statutory requirement. Entitlement to NEBs is for 104 weeks post-accident, with a four week waiting period. Mr. Sulkowski was entitled to $185 per week, which amounts to a maximum of $18,500. However, Unifund paid $19,425 to Mr. Sulkowski. Thus, it overpaid an amount of $925. As noted by Ms. Walker in her report dated July 30, 2020, "there is no documentation supporting why this additional period was issued." In its submissions, Unifund admitted that there had been an overpayment of $925 for which indemnity is not being sought.

[84] Travelers also took issue with the payment of $8,705 towards the disbursements incurred by counsel for the claimant and the cost of examinations, totalling $23,139.11. Travelers has claimed that disbursements are not payable under SABS or Ontario Regulation 283/95 and I must agree. I accept the proposition that as arbitrator, I have the equitable jurisdiction to consider reimbursement on the ground of unjust enrichment, as per Perell J. in *Ontario (Minister of Finance) v. Lombard Insurance Co. of Canada 2010 ONSC 1770*, but believe it ought be considered only in special circumstances as outlined in *HMQ v. The Dominion of Canada General Insurance Company / Travelers Insurance Company of Canada (Arbitrator Bialkowski – October 2, 2019), The Co-operators General Insurance Company v. Royal & SunAlliance Insurance Company, TD Insurance, Intact Insurance and Western Assurance Company (Arbitrator Bialkowski - December 11, 2018) and Echelon General Insurance Company v. Unifund Assurance (Arbitrator Bialkowski - December 16, 2019)*. I do not believe special circumstances exist here. Accordingly, such payment should not be the subject of indemnity. Cost of examinations are payments considered to be "benefits paid to or on behalf of the claimant" and are subject to indemnification.

[85] By way of summary, I find the following payments subject to indemnity:

Medical/Rehabilitation Prior to Full and Final Settlement	$ 80,595.77
Medical/Rehabilitation as Component of Full and Final Settlement	$ 300,000.00
Attendant Care Prior to Full and Final Settlement	$ 53,839.01
Attendant Care as Component of Full and Final Settlement	$ 340,000.00
Non-Earner Benefit Prior to Full and Final Settlement	$ 17,390.00
Non-Earner Benefit as Component of Full and Final Settlement	$ 370.00
Cost of Examinations	$ 23,139.11
Total Indemnity Sought from Travellers Insurance	$ 815,333.89

ORDER

[86] On the basis of the findings above, I hereby order that:

1. Travelers pay to Unifund $815,333.89 by way of indemnity;

2. Unifund assign to Travelers the benefit of the 10 year reversionary guarantee on the amount structured as part of the full and final settlement;

3. Travelers pay to Unifund interest on the aforesaid amount calculated pursuant to the *Courts of Justice Act;*

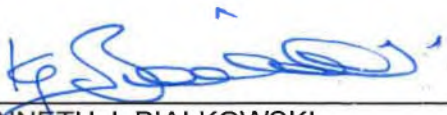
4. Travelers pay to Unifund its costs of this arbitration on a partial indemnity basis;

5. Travelers pay the Arbitrator's account.

[87] I will simply re-activate my file in the event that the parties cannot resolve the issues of interest and costs.

DATED at TORONTO this 30th)

day of September, 2020.)



KENNETH J. BIALKOWSKI
Arbitrator