The Insurance Amendment Act – One Year Later

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On September 1, 2014, the *Insurance Amendment Act* of Manitoba - formerly known as Bill 27 -became law. Substantially modelled on similar amendments which came into force in British Columbia and Alberta in July, 2012, the Manitoba amendments amounted to the most significant revisions to the *Insurance Act* in many years.

One year later, in this (brief) paper, we examine the (limited) judicial treatment which the amendments have received thus far. For simplicity, in this paper we will refer to the "New Act", meaning the *Insurance Act* as it now reads, post-amendment, and to the "Old Act", meaning the *Insurance Act* as it read prior to September 1, 2014.

A. REFRESHER: THE 'NOTEWORTHY' AMENDMENTS

The *Insurance Amendment Act* included a huge number of amendments to the Old Act, many stylistic only, but many substantive in nature. That said, the specific intent of this presentation is not so much to describe the amendments in whole or in part but to provide information about some recent decisions which may affect how some of the more consequential amendments will be interpreted. Nonetheless, we begin by briefly reviewing some of the amendments which are of a more substantial character.

1. Elimination of a discrete Part for "Fire Insurance"

Under the Old Act, insurance against damage and loss from the peril of fire was treated distinctly under Part IV with no real recognition that modern property insurance policies cover far more than the risk of fire. The result was that many provisions, and all of the statutory conditions, applied by operation of law only to policies which met the definition of "fire insurance", although in practical terms, the fire statutory conditions were made applicable to all coverages by condition.

The New *Act* does away with a discrete "fire insurance" part and shifts the content formerly found in Part IV into new Part 3, which applies to almost all types of insurance thus resolving any ambiguity about whether the statutory conditions apply to "all risks" insurance.

This reorganization was likely motivated by the Supreme Court of Canada decision *K.P. Pacific Holdings Ltd. v. Guardian Insurance Co. of Canada,* 2003 SCC 25 where the Court found that the fire statutory conditions did not apply to a loss because the policy was an "all-risk" policy, and therefore not a policy of "fire insurance" as defined in the legislation. The result was that a different limitation period applied than that stipulated under the fire statutory conditions.

2. Changes to the limitation period in Part III – "discoverability"

Section 136.2(2), contained in New Act Part III, applies to most insurance policies issued in the Province[1] and imports the notion of "discoverability" into Manitoba. This is a concept familiar in other jurisdictions, such as Ontario, but foreign to Manitoba. Section 136.2(2) provides:

> An action or proceeding against an insurer under a contract must be commenced
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> (a) in the case of loss or damage to insured property, not later than two years after the date the insured **knew or ought to have known** that the loss or damage occurred; and
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> (b) in any other case, not later than two years after the date that the cause of action against the insurer arose.

What is critical here is the language of "knew or ought to have known". This is known as a "discoverability" limitation period. Instead of the limitation period being tied to the date the loss and damage actually occurs (whether or not the loss/damages is then known to the insured), the limitation is tied to the date the insured "knew or ought to have known" that the loss or damage occurred.

Under former Fire Statutory Condition 14, the time within which to commence an action is tied to the date loss and damage occurred, *regardless of the plaintiff's knowledge*. Similarly, the *Limitation of Actions Act* in most cases ties the limitation period to the date the cause of action arose, regardless of the plaintiff's knowledge. Manitoba allows would-be plaintiffs who only discover their cause of action after the applicable limitation period has expired, to seek leave to commence an action on filing evidence establishing that, among other things, they were not aware of a material fact in relation to their intended cause of action until after the limitation period expired. Section 136.2(2) therefore represents a marked departure in that the limitation is tied to the plaintiffs insureds knowledge, rather than the occurrence of an objective event causing loss/damage.

As will be seen below, there is now at least one case interpreting similar wording in the B.C. *Insurance Act* which ties the date of "discovery" to the date the insurer rejects the claim.

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[1] the main exceptions being hail, automobile, life, accident and sickness insurance, which have their own limitation periods.

3. Waiver of terms/conditions

Under Old Act s. 123(1), "no term or condition of a contract shall be deemed to be waived by the insurer in whole or in part unless the waiver is stated in writing and signed by a person authorized for that purpose by the insurer."

In contrast, New Act s.123(1) provides that the insurer's conduct may also result in waiver where the conduct "reasonably causes the insured to believe that the insured's compliance with the requirement is excused in whole or in part":

> 123(1) The obligation of an insured to comply with a requirement under a contract is excused to the extent that
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> (a) the insurer has given notice in writing that the insured's compliance with the requirement is excused in whole or in part, subject to the terms specified in the notice, if any; or
>
> (b) the insurer's conduct reasonably causes the insured to believe that the insured's compliance with the requirement is excused in whole or in part, and the insured acts on that belief to the insured's detriment.
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> 123(2) Neither the insurer nor the insured is deemed to have waived any term or condition of a contract by reason only of
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> (a) the insurer's or insured's participation in a dispute resolution process under section 121;
>
> (b) the delivery and completion of a proof of loss; or
>
> (c) the investigation or adjustment of any claim under the contract.

As will be seen below, this provision introduces ambiguity and arguably makes it materially easier for an insured to argue that he/she should be relieved from some policy requirement due to conduct of the Insurer.

4. New mechanism to resolve the value of a loss

New Act section 136.8(2) provides for a new approach for the insured and insurer to resolve the value of a loss. The new section provides:

> "Instead of proceeding under statutory condition 11 [Appraisal] set out in Schedule B, an insurer and an insured may agree in writing to make a joint survey, examination, estimate or appraisal of the

> loss or damage, in which case the insurer is deemed to have waived its right to make a separate survey, examination, estimate or appraisal of the loss or damage."

5. Subrogation

New Act section 136.9(3) now provides that where an insured's interest in any recovery under an anticipated subrogated claim is limited to the amount provided by a deductible or co-insurance clause, the insurer has control of the action. Where the insured's interest exceeds that amount, and the insured and insurer cannot agree on matters such as the appointment of counsel, conduct of the action, including apportionment of costs, offers of settlement, etc., a mechanism is provided in section 136.9(4) for the insured and insurer to apply to the court for a determination of such disputes..

New Act section 136.9(6) further provides that a settlement or release does not bar the rights of the insured or the insurer unless they have concurred in the settlement or release. Note that this creates a tension in situations where the insurer has control of the action under s. 136.9(3). Surely the right to control the action must include the right to settle the action; yet there does not appear to be anything in the New Act suggesting that s. 136.9(6) does not apply to situations where the Insurer has control of the action pursuant to s. 136.9(3).

6. Changes affecting Life Insurance and Accident and Sickness Insurance

a) **Duty to disclose** - under Old Act s. 160, an applicant for life insurance was required to disclose in the application and through the application process "every fact within his knowledge that is material" and the failure to do so rendered the contract voidable by the insurer. No distinction was drawn between an initial application for insurance and a subsequent application for an increase to existing insurance.

   New Act s. 160(1) has not materially changed, but the New Act adds s. 160(3) which relates to the failure to disclose/misrepresentation of a fact in an application for **additional coverage** under an existing contract, an increase in life insurance under a contract or in any other change to the policy after the policy has been issued. The section now provides that disclosure/misrepresentations that fall within those categories render the contract voidable only in relation to the addition, increase or change.

b) **Grace period after lapse** – Old Act s. 159(2) essentially said that if a premium was not paid when due there was a grace period within which the premium could be paid of 30 days.

New Act s. 166(2) provides for a further period of 30 days without the necessity to prove insurability, as follows:

> "If a contract lapses at the end of a grace period because a premium due at the beginning of the grace period was not paid, the contract may be reinstated by payment of the overdue premium within a further period of 30 days after the end of the grace period, but only if the person whose life was insured under the contract is alive at the time payment is made."

Note that there is no requirement to prove insurability within the 30 day grace period after lapse. Under the Old Act, if the premium were not paid within the initial 30 day grace period, the insured would be entitled to seek reinstatement within two years by paying the overdue premium and producing evidence of good health and insurability. The reinstatement provision remains essentially the same in the amended *Insurance Act*; the difference lies in the extra 30 day period.

c) **Amendments to limitation periods** – Old Act s. 184(1) provided for a one-year limitation period to bring an action for the recovery of money payable in the event of a person's death; the New Act allows for two years and clarifies the language of s. 184(1).

Further, New Act s. 184(3), (4) and (5) are new limitation provisions targeted at providing certainty as to when claims must be commenced under short and long term disability policies and of how limitation periods are calculated when benefits are payable periodically:

> 184(3) Subject to subsection (5), an action or proceeding against an insurer for the recovery of insurance money not referred to in subsection (1) must be commenced not later than two years after the date the claimant knew or ought to have known of the first instance of the loss or occurrence giving rise to the claim for insurance money.

> 184(4) If insurance money is not payable unless a loss or occurrence continues for a period of time specified in the contract, the date of the first instance of the loss or occurrence for the purposes of subsection (3) is deemed to be the first day after the end of that period.

> 184(5) An action or proceeding against an insurer for the recovery of insurance money payable on a periodic basis must be commenced not later than the later of:
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> (a) the last day of the applicable period under subsection (1), (2), (3) or (4) or commencing an action or proceeding; or
>
> (b) if insurance money was paid, two years after the date the next payment would have been payable had the insurer continued to make periodic payments.

B. CASELAW SINCE THE AMENDMENTS

First, a disclaimer: the intent of this section is not to summarize any and all significant insurance cases decided in the year following the September 1, 2014, but to highlight recent cases which are relevant to the amendments themselves. In that regard, we did not expect to find many cases from Manitoba, given that the legislation has only been in force here for the last year, but we did expect to find a reasonable number of cases from British Columbia and Alberta; in fact there have only been a handful and of those, only a couple worth discussing.

1. Limitation Periods – "knew or ought to have known": *Kappei v. Allianz Global Assistance*, 2013 BCPC 415

Kappei is an interesting but (I hope) wrongly decided case from British Columbia which interprets s. 104(3) of the B.C. *Insurance Act*. Section 104(3) of the B.C. Act contains the limitation period for an action under an accident/sickness policy as follows:

> … an action or proceeding against an insurer for the recovery of insurance money… Must be commenced not later than two years after the date the claimant **knew or ought to have known** of the first instance of the loss or occurrence giving rise to the claim for insurance money.

This is the same language found in s. 184(3) of the New Act and, in using the language of "knew or ought to have known" is similar to the wording of the general limitation period in New Act s. 136.2(2).

In ***Kappei***, the question was when the insured first "discovered" her claim. The answer to that question would determine whether or not her action was barred by the limitation period in s. 104(3).

Ms. Kappei obtained travel insurance from Allianz before travelling to the United Kingdom from Canada. While in the U.K. she suffered severe back pain and ultimately underwent surgery incurring an out-of-pocket cost of $15,000. When she sought reimbursement from Allianz, her claim was rejected on the basis that the back injury was pre-existing. A final rejection letter was mailed on or about January 27, 2011. She then sought reimbursement through the Medical Services Plan of B.C., but only recouped $1,300 of her costs. Her dealings with the Medical Services Plan concluded by March 27, 2011.

Ms. Kappei filed an action against Allianz for the remaining medical costs on March 13, 2013. She argued that her claim was on time on the basis that she only "discovered" that she had a claim against Allianz after being denied full reimbursement by the Medical Services Plan on March 27, 2011.

The court disagreed and found the claim was out of time; however, and wrongly, in my respectful view, the court found that the limitation period began to run from the date of the final rejection letter from Allianz, delivered on or about January 27, 2011:

> … In my view, the claimant clearly knew or ought to have known on or about January 27, 2011 that the Defendant was denying coverage of her claim. That is why she turned to the Medical Services Plan in hopes of obtaining reimbursement for expenses from that source instead. **Thus, the final denial contained in the letter from the Defendant of January 27, 2011 was the triggering event under s. 104(3) - the "loss or occurrence" giving rise to her claim for insurance money**. Certainly the claimant hoped not to have to sue the Defendant and, as a result, sought recompense elsewhere. But, making a decision to pursue other options, if at all possible, does not change the fact that the claimant knew as soon as she received the Defendant's letter of January 27, 2011 that she was being denied coverage. **That was the date her cause of action against the Defendant was "discovered" because it was clear to the Claimant at that point that the only option to successfully claim insurance money from the Defendant, was by launching a claim through court**.

Is this reasoning correct? Is this what "discoverability" means? In my view, no.

Notice that the limitation period refers to the "first instance *of the loss or occurrence giving rise to the claim* for insurance money". A denial of coverage is not an 'instance of loss' giving rise to a claim. On the contrary, the "first instance of loss giving rise to a claim" probably occurred when Ms. Kappei actually incurred the medical costs. Moreover, she obviously knew that she had a claim in respect of such costs on or

before the date that she filed her initial claim with Allianz. To speak of "discovering" a claim only after receiving a denial letter must be wrong.

In my view, when called upon to interpret the new "discoverability" limitation periods in the New Act, the Manitoba Courts should properly focus on the date the insured knew or ought to have known that she sustained loss or damage, without any regard to the date the insured received the insurer's position on the claim.

Manitoba Courts have considerable experience with the concept of when a claimant first "knew or ought to known" all the material facts underlying a cause of action in the context of applications to extend a limitation period under s. 14 of *The Limitation of Actions Act*. In that regard, the focus is on when the claimant first knew, or could have known, the material facts, *not* on the proposed defendant's position vis-a-vis the matter.

That said, until the new limitation periods receive thorough treatment in Manitoba, we may see attempts to use the decision in ***Kappei*** as authority for the proposition that the new limitation periods in the New Act only begin to run from the date of a *final denial* of coverage.

2. Conduct Amounting to Waiver? *Dhillon v. Anderson* 2014 ABQB 609

Dhillon considered an argument that an insurer was estopped (barred) from relying on a limitation period because of the conduct of it or its agents. In that regard, the case relates to New Act s. 123(1)(b). That said, this case is presented *not* as an example of a court interpreting wording similar to New Act s. 123(1)(b), but as a contrast between the traditional test for a promissory estoppel and what I submit is a relaxed, easier to satisfy test under s. 123(1)(b).

The case involved a claim for first party coverage following an automobile accident on March 24, 2011. The Statement of Claim was filed in October 2013, well past two years following the motor vehicle accident. The insurer moved for summary judgment on the basis of the missed limitation.

The evidence before the court was that the insurer had not specifically informed the plaintiff of the applicable limitation period and that he only retained a lawyer after being told that the limitation period had passed. In this regard, critically, the accident occurred shortly before certain sections of the *Fair Practices Regulation* of Alberta came into force. Those regulations oblige an insurer to provide notice of an applicable limitation period, but did not apply retrospectively.

In the two years following the accident, the plaintiff had been in regular contact with adjusters for the insurer concerning his injuries, treatment, prognosis and settlement. Regarding settlement, the evidence was that the insurer had made an offer shortly after the accident and had made further offers subsequently.

In February 2013, just a month before the two year anniversary of the accident, the plaintiff spoke with the adjuster who requested a copy of a recent MRI and doctor's report. The adjuster advised the claimant that she would be away for two weeks and that she would contact him on her return to discuss settlement. The claimant faxed in the requested reports and waited for the promised call. He received no contact and approximately three weeks later began a series of unsuccessful attempts to reach her by telephone. Ultimately, he spoke to her on June 11, 2013 at which time she advised that if he had not already filed a statement of claim, the insurer would no longer deal with him given that the limitation period passed.

The insured argued that the sequence of events and conduct of the defendant, through its adjuster, in making settlement offers, requesting additional medical materials, and advising that the insured would be contacted on the adjuster's return to the office amounted to a promise and/or conduct that it was not necessary to issue a claim within the limitation period.

The court analyzed the issue by considering the traditional definition of promissory estoppel from the Supreme Court of Canada in ***Maracle v. Travelers Indemnity Co. of Canada***, [1991] 2 S.C.R. 50 where the court said:

> The principles of promissory estoppel are well settled. The party relying on the doctrine must establish that the other party has, by words or conduct, made a promise or assurance which was intended to affect their legal relationship and to be acted on. Furthermore, the representee must establish that, in reliance on the representation, he acted on it or in some way changed his position.

Note that this test for focuses first on the intention of the alleged promisor (insurer). That is, under the traditional test, the first question is whether the statement or conduct was intended *by the Insurer* to affect its legal relationship with the Insured. The second question is whether the Insured relied on that promise/conduct and acted to change his position.

Contrast this with section 123(1)(b) in the New Act:

> 123(1) The obligation of an insured to comply with a requirement under a contract is excused to the extent that

> …
>
> (b) the insurer's conduct ***reasonably causes the insured to believe*** that the insured's compliance with the requirement is excused in whole or in part, and the insured acts on that belief to the insured's detriment.

Under the New Act, the analysis still requires some conduct by the insurer, but the first question has changed: it appears to matter not whether the insurer intended to affect the legal relationship. The first question is whether the conduct caused the insured to *reasonably believe* that compliance with a requirement was excused.

In other words, the New Act focuses on the state of mind of the insured and not the intention of the insurer: arguably, the intention of the insurer is irrelevant. Moreover, the New Act does not explain whether 'reasonableness' is considered in relation to *this particular insured*, or in relation to *an objectively reasonable insured*.

Insureds come in all levels of intellect and sophistication. Imagine a particularly obtuse and unreasonable insured. In focusing on the reasonableness of the insured's belief, is the court to ask whether the conduct reasonably caused *this particular obtuse and unreasonable insured* to believe something, or whether the conduct was of such a nature that an objectively reasonable, non-obtuse insured would believe the same thing? In my view, the New Act is not clear.

In short, the New Act expands the circumstances where conduct of the insurer will give rise to an alleged estoppel. This makes it all the more critical that communications with the insured are as clear and unequivocal as possible, and, to the extent possible, that they be communicated or subsequently confirmed in writing so that a reliable record of what has been communicated and what has occurred exists.

In ***Dhillon*** the test for promissory estoppel was not met because there was no evidence that would allow the trier of fact to infer that there was an intention on the part of the insurer to affect its legal relations with its insured. The insured's assumption that the matter was headed for settlement and not litigation was insufficient to meet the test. However, if the court had been considering the same language as s. 123(1)(b), the result may have been different inasmuch as there would have been a greater emphasis on the insured's state of mind.

The coming years will undoubtedly see a greater number of cases interpreting the many amendments embodied in the New Act. For the time being it is safe to say that, as necessary as an overhaul of the Old Act was, a number of the amendments have created an opportunity for additional disputes and conflicting interpretations.