Focus INSURANCE

The power of plain language

British Columbia decision examines the fine print of an insurance policy

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Nick Safarik

Insurers and their counsel are well aware of the risk that an ambiguous provision of an insurance policy will be construed contra proferentum – against the insurer – if the ambiguity cannot be resolved through application of the general principles of insurance policy interpretation as set out in the Supreme Court of Canada's decision in *Progressive Homes Ltd. v. Lombard General Insurance Co. of Canada* [2010] S.C.J. No. 33. Despite the modern trend towards the use of "plain language" in order to avoid ambiguity in insurance policies, many insureds continue to argue ambiguity exists when coverage under the policy is denied. In *Strata Plan KAS3058 v. St. Paul Fire and Marine Insurance Company (c.o.b. Travellers)* [2013] B.C.J. No. 2651, the Supreme Court of British Columbia recently upheld an insurer's denial of coverage under an extension to the loss of revenue coverage for interruption by a civil authority, and found that the insureds were "simply searching for or creating ambiguity" where none existed.

The co-plaintiff, Strata Plan KAS3058, is a strata corporation whose members are owners of strata lots and common property of a condominium complex known as Cove Lakeside Resort, located in the municipal district of West Kelowna, B.C. Certain units at the resort are available for rent through a rental pool operated by the co-plaintiff, 0739152 B.C. Ltd. The plaintiffs were named insureds under a policy issued by the defendant, St. Paul Fire and Marine Insurance Company, doing business as Travellers, which provided property insurance for Cove Lakeside Resort.

On July 18, 2009, West Kelowna issued an evacuation order for the area surrounding the resort as a result of wildfires in the area. The evacuation order was lifted three days later.

As a result of a significant number of cancelled rental bookings at the resort in the weeks after the evacuation order was lifted, the plaintiffs presented their insurer with a proof of loss of rental income between July 19 and Aug. 31, 2009, in the amount of $463,287.50. Although the defendant insurer agreed that the policy afforded coverage for the plaintiffs' loss of rental income during the time the evacuation order was in effect, it denied coverage for the plaintiffs' claims in the period after the order was lifted.

The extension of coverage for loss of revenue for interruption by a civil authority in the insurance policy provided as follows: "We will pay your actual loss of revenue when a civil authority denies access to an insured location as a direct result of physical loss or damage by a covered cause of loss to property not at an insured location. We will pay for loss of revenue for up to four consecutive weeks while access to an insured location is denied."

Arguing that the civil authority clause was ambiguous, the plaintiffs submitted that each of the sentences in the clause had a different meaning and provided a separate grant of coverage. The plaintiffs argued that the first sentence established an entitlement to coverage that started when a civil authority denied access, but did not restrict the covered losses to the period during which access was denied. According to the plaintiffs, when read as a whole, the coverage provided by the clause included reimbursement for revenue losses suffered while access was denied and due to the impact of denial of access, including consequential losses after the evacuation order was lifted.

As there appeared to be no Canadian authorities interpreting similar civil authority clauses, the defendant insurer relied upon U.S. cases that considered the scope of coverage under civil authority clauses. Justice Margot Fleming noted that courts in both B.C. and other Canadian jurisdictions have recognized U.S. cases as persuasive authority in matter of insurance law and policy interpretation. Relying on the U.S. cases and the language of the clause itself, the defendant insurer argued that the meaning of the clause was unambiguous. According to the insurer, when the clause was read as a whole, it was plain that the second sentence was directly related to and modified the first, and clearly contemplated the requirement that there be a denial of access for coverage to continue, and that such coverage was limited to a maximum of four weeks.

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Insurers should not rely on social programs

Patrick Brown

When a child or adult suffers a severe traumatic brain injury or spinal cord injury, the costs for care into the future are significant. Failure to adequately address the needs of a severely disabled client through medical evidence and a solid life care plan can have a disastrous impact on the case. Since the needs are for a lifetime, many items equate to high figures.

Traditionally, the insurer and defence counsel have contested the care costs items on the basis that the specific item being sought is either not needed to the extent asserted, is unreasonable, or the market rates are much lower. These legitimate arguments have controlled unreasonable and exaggerated wish lists when presented by overzealous life care planners. On occasion, however, the insurer will go beyond these legitimate arguments and seek to reduce their exposure by relying on social welfare programs. In other words, the life care planner simply asserts in their report that the item should not be allowed because publicly funded social service nets are in place to care for the plaintiff.

This argument is more prevalent when the severely disabled person does not have access to collateral benefits and must rely on social safety nets to survive while their case is pending. The programs include March of Dimes, Ontario Trillium Fund, Community Care Access Centres, the Residential Rehabilitation Assistance Program, and others. This line of attack has been rejected repeatedly by our courts. Despite the rejection, certain life care planners still try to reduce claims on this basis.

> An insurer's attempt to reduce a disabled person's standard of living to one that is supported by only marginal levels of uncertain assistance must be resisted by counsel. It is an approach that runs counter to the most basic principles of the law.
>
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In the seminal decision of *Andrews v. Grand & Toy Alberta Ltd.* [1978] 2 S.C.R. 229, the Supreme Court held that the purpose of the care costs is meant to improve the mental and physical health of the injured person, not simply sustain it. The court in *Andrews* went on to hold that the assessment of future care costs should not consign the injured person to a minimum standard of living. The obligation is to do more than simply "provide." Unfortunately, this is exactly what social welfare programs do. The other inherent flaw is the very real possibility that the funding for the particular government program will cease to exist or be reduced well after the trial or settlement. This is in addition to the constantly changing eligibility requirements that can leave the disabled person on the outside, without any help or recourse.

There are also troubling implications for a disabled person's family members. In essence, the reduction of services provided to them will simply place the shortcomings on the shoulders of their loved ones. In *Marcoccia (Litigation Guardian of) v. Gill* [2007] O.J. No. 1333, where a 20-year-old catastrophically injured plaintiff was awarded future care costs based on an assessment that excluded family support, Justice Patrick Moore specifically held that "for the purposes of assessing future claims, the family must be taken out of the picture."

Courts have fortunately recognized the problems with reducing awards due to social programs and have not allowed the costing to be reduced when the argument is advanced. In *Stein (Litigation Guardian of) v. Sandwich West (Township)* [1993] O.J. No. 1772, Justice Thomas Zuber held that a reduction in the future cost of care for government-funded services should not be permitted due to "the uncertain expectation of government help." The Ontario Court of Appeal upheld this finding and adopted the argument that victims of tortfeasors should not be forced to accept all publicly funded services, nor should service levels provided by social programs form the standard for tort compensation. Indeed, as it was held by Justice A. Paul Dilks in *MacLean v. Wallace* [1999] O.J. No. 3220, if one party must bear the risk of uncertain government funding, it ought to be the defendant.

An insurer's attempt to reduce a disabled person's standard of living to one that is supported by only marginal levels of uncertain assistance must be resisted by counsel. It is an approach that runs counter to the most basic principles of the law. A plaintiff ought to be entitled to compensation for their necessary and reasonable expenses. While they are certainly not entitled to a life of decadence following an injury, they need not accept a life that provides, at best, a minimum standard of living. In addition, life care planners must ensure that the principles of compensation as determined by jurisprudence should guide their life care plans. To ignore such fundamental principles of law may jeopardize their ability to be qualified as an expert.

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Interpretation: U.S. cases accepted as authority

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Overall, Justice Fleming accepted the insurer's interpretation, and found that the plaintiffs' proposed interpretation of the second sentence of the clause rendered most of it, including the very clear four-week claims limit, meaningless. Noting that the drafters had attempted to use "plain language" throughout the policy, she found that when the ordinary language of the clause was considered as a whole and in its context, coverage was only provided for loss of revenue that occurred *when* a civil authority denied access, and *while* it continued to do so, for a maximum period of four consecutive weeks.

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Although the applicability of the court's decision in *Strata* is somewhat limited by the specific language of the insurance policy under consideration, insurers should take comfort in the court's simultaneous recognition of the insurance industry's efforts to use "plain language" and its refusal to find ambiguity where none exists.

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