Accident Benefits Update: We survived 2020!

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2020 was a year unlike any other (and hopefully unlike any other to be seen again).

When the pandemic struck, the LAT, like many tribunals and even our court system, was unprepared. In-person hearings were cancelled. Those that could, were converted to telephone hearings. It was not until several months later that the LAT was equipped to run virtual hearings through Microsoft Teams. The already backlogged system was even further backlogged, causing widespread delay and frustration among stakeholders.

But thankfully this is not the end of the story. 2020 also brought positive changes at the LAT. A new Executive Chair was hired, tremendous efforts were put into modernizing LAT operations, stakeholder consultation meetings were re-initiated and changes were made to a number of LAT procedures.

Unfortunately, not everything changed. Many LAT decisions continued to be inconsistent with prior decisions, exacerbating the uncertainty stakeholders face and increasing frustrations. Orders for interim benefits and special awards also continued to be essentially non-existent.

The following paper outlines the current state of the LAT, as well as a number of key 2020 decisions of practical importance to all stakeholders.

I. <u>Modernization Efforts</u>

Modernization is one silver lining of the pandemic. With hearings at a near standstill in March, the LAT was forced to move into the 21st century.

The following are some of the key highlights of the changes made this past year:

a) Video Conferencing Hearings Now Available

LAT hearings may now be conducted by video conference using Microsoft Teams. The formal etiquette and protocols of in-person proceedings apply to remote hearings. A comprehensive "Guide to Videoconferencing Proceedings and Microsoft Teams" (last updated on August 11, 2020) can be found on the LAT's website.[1]

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[1] Licence Appeal Tribunal. *Guide to Videoconferencing Proceedings and Microsoft Teams*. Retrieved at: https://tribunalsontario.ca/en/videoconferencing/

b) In-Person Hearings Are Now Limited

On or around November 30, 2020, Tribunals Ontario released an updated Practice Direction regarding the format for hearings.[2] It indicates that "**moving forward, all matters will proceed as written or electronic hearings with two exceptions:**

1. **The first exception is that an in-person hearing may be provided if a party can establish that an in-person hearing is required as an accommodation for an Ontario *Human Rights Code*-related need.**

2. **The second exception is where a party can establish that the hearing format will result in an unfair hearing."**

To have an in-person hearing, the party requesting the format change will need to establish, at a minimum, that the hearing format will likely cause **significant prejudice**.

The Tribunal may also decide that the hearing will proceed as a combination of different formats (i.e., with one party attending the Tribunal's hearing room in person, and another party attending the hearing electronically).

When assessing a party's request to change the hearing format, the Tribunal is to consider factors, including:

- whether fairness requires the hearing format to be changed;
- whether a party will be prejudiced by the current hearing format, or would be prejudiced if the hearing format were to change;
- the complexity of the matter;
- the length of the delay that will result if the matter waits for an in-person hearing;
- any factor that may be relevant to the legislation under which the matter arose; and
- any other factor that is relevant to the appropriate hearing format.

Based on the above, it is clear that in-person hearings will now be extremely rare.

c) Document Naming Convention Published

The LAT published a guide to assist with submitting digital documents via e-File. This guide outlines the naming convention to be used for such documents. The Guide and Naming Convention can be found on the LAT's website.[3]

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[2] Tribunals Ontario. *Updated Practice Direction on Hearing Formats, November 30, 2020*. Retrieved at: https://tribunalsontario.ca/documents/TO/Practice-Direction-on-Hearing-Formats-EN.html

[3] Tribunals Ontario. *LAT AABS eFile Instructions and Naming Convention*. Retrieved at: https://tribunalsontario.ca/assets/uploads/2020/09/LAT-AABS-eFile-Instructions-and-Naming-Convention.pdf

d) Parties Can Now Schedule their Own Case Conferences

The LAT also announced a pilot program to enable parties to schedule their own case conferences (rather than having a date assigned).

The pilot program is to run between November 16, 2020 and February 26, 2021. It applies to applications filed on or after November 16, 2020 that involve issues of catastrophic injury or determination. The program is an effort to reduce the number of adjournment requests and enable parties to select the initial case conference date that most suits their needs.

In more practical terms, the pilot program works as follows:

- The LAT will provide a date range for case conference in their response request email. The parties are then to provide the LAT with mutually agreeable date(s) for case conference.

- If the parties cannot agree on a date, or dates are not provided, or the dates provided fall outside the range submitted by the LAT, the LAT will schedule the case conference based on the earliest availability.

- The LAT will then set the date and deliver the Notice of Case Conference within 30 days.

- An adjournment request will be required if the parties wish to change the case conference date *after* the Notice of Case Conference has been issued. Of note, r*equests to adjourn the case conference date may not be granted*.

It is hoped that upon completion of the pilot program, the LAT will expand the ability of parties to schedule their own case conferences to all LAT matters.

e) More Changes to Come?

Sean Weir was appointed Executive Chair of Tribunals Ontario on June 2, 2020. He has extensive experience in operational and governance management. He was previously the Chief Executive Officer and National Managing Partner of Borden Ladner Gervais.

Under Mr. Weir’s leadership, the Associate Chairs of the various branches of Tribunals Ontario were directed to re-engage with stakeholders. There had unfortunately been a prior freeze on stakeholder consultations.

In September 2020, The LAT AABS unit met with a number of stakeholders, including representatives of the Advocates Society. This meeting was very encouraging with the LAT highlighting a number of plans to improve upon its services, including:

- the addition of 10 adjudicators (although this unfortunately did not happen by year end as was expected);

- a simplified procedure that would streamline simple applications and as a result, reduce delay and costs; and

- revised rules and practice directions to reduce the number of motions required.

Mr. Weir's contract was renewed in December 2020. It is expected that the LAT will continue its engagement with stakeholders and hopefully further improve its operations.

II. Trends in the Case Law

Unfortunately, not much changed on this front in 2020.

There continued to be inconsistencies in the decisions released. In ***HCK v Aviva Insurance Company*, 2020 ONLAT 18-011956/AABS**,[4] Adjudicator Johal made clear that adjudicators are not bound by prior Tribunal decisions, stating as follows:

> [15]… adjudicators are not bound by previous tribunal decisions and the reason for that is that the role of the Tribunal is to provide a cost-effective and timely decision on the facts of each case. Adjudicators should not have to spend an inordinate amount of time reviewing Tribunal case law and providing reasons on why a case being relied upon by a party should not be followed. To be bound by Tribunal jurisprudence would hinder the independence of an Adjudicator as they must be free to focus on the facts at hand and arrive at a conclusion that is just and reasonable in accordance with the *Schedule*.

Special awards also continued to be essentially non-existent.

While there was a glimmer of hope for claimants in 2019 when Adjudicator Punyarthi granted the highest special award ever at the LAT (25% of the attendant care and home modification benefits awarded which totaled more than $300,000) in ***SM v Unica Insurance Inc,* 2020 CanLII 12718 (ON LAT)**[5], this decision was overturned on reconsideration in ***SM v Unica Insurance Inc,* 2020 ONLAT 18-010164/AABS**.[6] Adjudicator Boyce found that the insurer's conduct did not justify the magnitude of the award.

SM involved, amongst other issues, an attendant care dispute. The special award was initially granted by Adjudicator Punyarthi because the insurer failed to investigate the

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[4] *HCK v Aviva Insurance Company*, 2020 ONLAT 18-011956/AABS (CanLII). Retrieved at: <http://canlii.ca/t/j9j7d>

[5] *SM v Unica Insurance Inc*, 2020 ONLAT 18-010164/AABS (Decision) (CanLII). Retrieved at: <http://canlii.ca/t/j5brz>

[6] *SM v Unica Insurance Inc*, 2020 ONLAT 18-010164/AABS (Reconsideration) (CanLII). Retrieved at: <http://canlii.ca/t/j5brz>,

claimant's attendant care needs after receiving a new Form 1 and focused on its own OT reports (ignoring other evidence including its own assessors who found the claimant to be catastrophically impaired and in need of significant assistance).

In overturning the decision on reconsideration, Adjudicator Boyce relied heavily on the language and reasoning in *Plowright v Wellington Insurance Co,*[7] a 1993 FSCO decision and imposed a very high bar for a special award to be granted, stating:

> [39] It is well-settled that an award should not be ordered simply because an adjudicator determined that an insurer made an incorrect decision. Rather, in order to attract a s. 10 award, the insurer's conduct must rise to the level described in *Plowright* – it must be excessive, imprudent, stubborn, inflexible, unyielding or immoderate.

Adjudicator Boyce also went on to note that insurance adjusters are not held to a standard of perfection:

> [51] With great respect, I trust this is obvious: insurance adjusters are not medical professionals and they should not be held to that standard. Insurance companies have a duty of good faith to adjust an insured's file as claims are submitted, as new information becomes available, as their condition deteriorates, *etc.* However, **while there is a duty of good faith, I find it is unreasonable and quite unfair to expect adjusters who come and go with some regularity to micromanage the assessments of qualified professionals to ensure that their reports respond directly to the specifics of a claim or else risk exposure to a s. 10 award if they do not.** Generally, insurers should be able to rely on the expertise of professional assessors who conduct specific assessments for benefits under the *Schedule* in good faith. I find it was unreasonable of the Tribunal and an error to order a s. 10 award on the basis that Unica's adjuster should have ensured that Ms. Ghatas asked S.M. about cuing, emotional support and night time supervision. This requirement—which I find differs from an insurer's obligation to secure an addendum report in the face of new medical information or opinion—would unfairly and perhaps even recklessly extend the scope of an adjuster's responsibilities moving forward.

Despite the high bar for special awards, all is not lost. In ***FA-W v Aviva General Insurance Company, 2020 ONLAT 18-008742/AABS***[8]*,* Adjudicator Norris made a special award equal to 20% of the benefits denied.

In *FA-W*, the Applicant sought payment for catastrophic assessments conducted. The Applicant provided the insurer with the relevant case law supporting the requirement to pay same outside the medical/rehabilitation limits. The insurer responded stating that, despite being aware of the decision in question, it continued "to maintain the position that the assessments are payable from the medical benefit policy limit" (para 13).

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[7] *Plowright v Wellington Insurance Co*, 1993 CarswellOnt 4786, [1993] OICD No. 62, File No.: A-003985 (FSCO Arb).

[8] *FA-W v Aviva General Insurance Company*, 2020 ONLAT 18-008742/AABS (CanLII). Retrieved at: <http://canlii.ca/t/j5brs>

Adjudicator Norris determined that the insurer's blatant disregard for the prior LAT decisions justified a special award, stating that:

> [15] ***The above decisions…may not be binding on this Tribunal. However, this does not give licence to the [insurer] to ignore the jurisprudence***. These decisions provide a guideline on how catastrophic assessment costs are allocated. It would be reasonable to follow the findings in the absence of any counter authority. The [insurer] provides no caselaw or other historical basis for its position. [emphasis added]

III. Interesting Cases

There were also a number of interesting cases that were released in 2020. While many are fact specific and some are seemingly inconsistent, they do give us some direction as to what to expect from the LAT.

(a) Once CAT Always CAT?

Per s. 3.1(1)2(iii) of the *Schedule*, an impairment is a catastrophic impairment if it results in a "severe and permanent alteration of prior structure and function involving one or both legs as a result of which the insured person's score on the *Spinal Cord Independence Measure* ("SCIM") for indoor mobility*…and applied over a distance of up to 10 metres on an even indoor surface is 0 to 5*."

For the first time, the LAT dealt with the post-June 1, 2016 interpretation of this section and specifically the issue of permanence (i.e., what happens if the insured's score subsequently increases).

In **Patchett v Optimum Insurance Company, 2020 ONLAT 19-008902/AABS**[9], the applicant was injured in a February 2018 collision. She suffered severe injuries to her right knee, ankle, and lower extremity, requiring surgical repair. She developed significant infections and was hospitalized until June 2018.

The insurer agreed that, as of September 2018, the Applicant's injuries resulted in a score of five or less on the SCIM for indoor mobility, which would qualify her as catastrophically impaired. In a subsequent Application for Catastrophic Determination submitted in March 2019, the Applicant scored four on the SCIM scale, continuing to meet the CAT definition.

The insurer arranged s. 44 assessments which resulted in an SCIM score greater than five. The insurer therefore denied catastrophic determination. The issue in dispute was

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[9] *Patchett v Optimum Insurance Company*, 2020 ONLAT 19-008902/AABS (CanLII). Retrieved at: <http://canlii.ca/t/jc3z4>

whether the prior SCIM scores of less than 5 would qualify the Applicant for catastrophic determination per s. 3.1(1)2(iii) of the Schedule.

Since criteria 2 had not previously been interpreted through the case law, Vice Chair Boyce offered a brief explanation of the SCIM, particularly item 12:

> [10] The SCIM assesses traumatic and non-traumatic, acute and chronic spinal cord injuries. It was developed to specifically address the ability of individuals with spinal cord injuries to accomplish various functional activities and was added to criteria under s. 3.1 of the Schedule as part of the O. Reg. 251/15 amendments.

In accordance with item 12 of the SCIM, a score is assigned to the applicant based on his or her mobility indoors and the use of mobility aids (such as a crutch or walker) while walking on an even surface for up to 10 metres. A score between zero and five is required to meet the CAT threshold.

The Applicant submitted that on plain reading of the section, she met the catastrophic definition because the word "permanent" in s. 3.1(1)2(iii) only referred to the alteration of prior structure and function of her lower extremity, and made no reference to the measurement under item 12 of the SCIM being a permanent score between zero and five.

In contrast, the insurer argued that deeming the applicant catastrophically impaired based on a temporary SCIM score between zero and five that did not result in permanent impairment led to an absurd interpretation, contrary to the intention of the legislature.

Vice Chair Boyce agreed with the insurer, opining that

> "criteria 2(iii) requires a permanent impairment in alteration of function in the leg, measured by a permanent score between zero and five on Item 12 of the SCIM... registering a score between zero and five on the SCIM on a temporary basis at any single point post-accident is not sufficient to receive a CAT designation where that mobility impairment... is not a permanent one" (paras 19-20).

Catastrophic designation was therefore denied. A single score will not rise to the threshold of catastrophic. As noted by Vice Chair Boyce, "all criteria under s. 3 require permanency of impairment".

(b) <u>Does Discoverability Apply to Specified Benefits?</u>

As was discussed at this conference last year, the Court of Appeal held in ***Tomec v Economical Mutual Insurance Company,*** **2019 ONCA 882**[10] that the two-year limitation period for statutory accident benefits is not a "hard" limitation period. The discoverability principle applies. The limitation period does not begin to run until the benefit is denied.

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[10] *Tomec v Economical Mutual Insurance Company*, 2019 ONCA 882 (CanLII). Retrieved at: <http://canlii.ca/t/j37sh>

And for there to be a denial, the insured must be eligible to receive the particular benefit in the first place.

In 2020, the LAT dealt with the issue of how, if at all, to apply *Tomec* to specified benefits. ***RS v Pafco Insurance Company*, 2020 ONLAT 19-006311/AABS**[11] dealt with, amongst other issues, an IRB denial. The Applicant previously received IRBs. The IRBs were terminated prior to 104-weeks. The Applicant thereafter sought IRBs post-104 weeks.

The Applicant relied on the *Tomec* decision, arguing that the limitation period to claim IRBs had not expired due to the operation of the doctrine of discoverability. The Applicant argued that entitlement to IRBs pre 104-weeks and post-104 weeks constituted separate causes of action. The cause of action for post-104 week IRBs does not accrue until the insured person has been disabled for at least 104 weeks.

Adjudicator Boyce held that *Tomec* did not intend to extend the doctrine of discoverability to specified benefits, and concluded that the Applicant was statute-barred from proceeding with his IRB dispute as he failed to appeal the insurer's valid denial within the applicable limitation period. For the purposes of IRBs, an insured's loss is crystalized when a notice of termination is received. Because the Applicant previously received the benefit, Adjudicator Boyce found it difficult to reconcile how the Applicant would not have discovered his entitlement to claim the benefit until sometime later.

Of note, the same adjudicator made two prior seemingly inconsistent decisions (although they certainly turn on the differences in the facts). The first is ***PV v Economical Insurance,* 2019 ONLAT 19-000069/AABS.**[12] The Applicant did not initially require IRBs. He continued to work on a full-time basis for more than 3 years after the accident. Over time, however, his accident-caused impairments began to interfere with his ability to work and eventually he ceased working altogether and made application for IRBs. The insurer denied the application.

In the preliminary issue decision[13], Adjudicator Boyce upheld the IRB denial because the Applicant failed to apply for IRBs within two years of the accident. The application for IRBs was deemed to be too late.

Adjudicator Boyce, however, granted the Applicant's request for reconsideration holding that the Applicant's "substantial inability" to perform the essential tasks of his employment was not discoverable within the two year limitation period. It "accrued" over time as his impairments increased and his ability to work diminished.

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[11] *RS v Pafco Insurance Company*, 2020 ONLAT 19-006311/AABS (CanLII). Retrieved at: <http://canlii.ca/t/j7t2x>

[12] PV v Economical Insurance, 2019 ONLAT 19-000069/AABS (Reconsideration) (CanLII). Retrieved at: <http://canlii.ca/t/j5bsb>

[13] *PV v Economical Insurance*, 2019 ONLAT 19-000069/AABS (Preliminary Issue Decision) (CanLII). Retrieved at: <http://canlii.ca/t/j33w9>

Adjudicator Boyce noted that the *Tomec* decision made clear that “the applicable limitation period is tied to the accrual of the cause of action” (para 15). While the Court of Appeal’s decision in *Tomec* had not yet been released at the time of the preliminary issue decision in this matter, Adjudicator Boyce noted that it “is binding on the Tribunal” (para 10). Adjudicator Boyce held that the Applicant:

> did not “discover” his claim for IRB until his substantial inability to perform the essential tasks of his employment surfaced. To allow an insurer to pre-emptively deny IRB entitlement where it was not explicitly claimed (and where there was no eligibility) and then also strictly adhere to the limitation period to reinforce that denial would, in my view, undermine the consumer protection nature of the *Schedule* and the policy rationale of limitation periods.

The second case is ***BET v Wawanesa Mutual Insurance Company*, 2020 ONLAT 19-008722/AABS**[14] wherein Adjudicator Boyce allowed a “fresh” non-earner benefit (“NEB”) claim to be advanced well after the limitation period expired.

The Applicant suffered injuries in a 2013 collision. She received non-catastrophic medical and attendant care benefits and NEBs from the insurer for several years. Her physical impairments eventually began to improve and she went on to graduate, began full-time work, and was able to care for her family.

The Applicant’s psychological condition, however, subsequently declined interfering with her ability to maintain employment. She also began to struggle with her day-to-day activities. A new OCF-3 was submitted to the insurer, confirming that the Applicant had again developed a complete inability to lead a normal life. Wawanesa denied the Applicant’s NEB claim on the basis that it previously denied same and the limitation period to dispute the denial had expired.

The main issue in dispute was whether the Applicant’s claim was statute-barred. The Applicant argued that her second claim for NEBs was not discovered until after her psychological condition deteriorated to the point where she would meet the complete inability test. Her eligibility for NEB had in essence “re-accrued” or “accrued-anew”.

Wawanesa argued that the Applicant previously received NEBs and it would be disingenuous to argue that she did not discover her claim for NEBs. Wawenesa also pointed to the Applicant’s prior challenge to the NEB termination that was brought at FSCO and subsequently withdrawn. Wawanesa argued that the Applicant was trying to re-apply for a terminated benefit beyond the limitation period.

Adjudicator Boyce relied on the principles outlined in *Tomec*, finding that “Wawanesa’s insistence on a hard limitation period… penalized [the Applicant] for getting better and later having her condition deteriorate” (para 20). Adjudicator Boyce concluded as follows:

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[14] *BET v Wawanesa Mutual Insurance Company*, 2020 ONLAT 19-008722/AABS (CanLII). Retrieved at: <http://canlii.ca/t/jblq9>

> [25] As *Tomec* prescribes, to bar [the Applicant's] appeal on the basis of Wawanesa's 2016 denial would mean the two-year limitation period started before [the Applicant's] psychological condition deteriorated to the point that her cause of action was even discovered. This is absurd. Accordingly, on the basis of the discoverability doctrine, I find [the Applicant] is not statute-barred from proceeding with her NEB claim under s. 56.

So, does *Tomec* apply to specified benefits? Despite Adjudicator Boyce's finding in *RS,* it would seem it does given the right set of facts.

(c) Deficient Notice? IE Reports to be Excluded

In ***BM v Unica Insurance Inc*, 2020 ONLAT 19-009381/AABS**[15] the insurer issued deficient Notices of Examination (OCF-25s). The Notices did not clearly state the "medical and any other reasons" for the relevant s. 44 examinations. Per s. 44(5) of the *Schedule,*

> If the insurer requires an examination under this section, the insurer shall arrange for the examination at its expense and shall give the insured person a notice setting out,
>
> > (a) the medical and any other reason for the examination …

The insurer's Notice of Examination stated:

> This examination is being conducted to determine if the requests treatment plans dated November 17, 2016 in the amount of $2294.49 recommending physiotherapy and December 1, 2016 $2470.98 recommending occupational therapy both submitted by Ross Rehab [sic]

While Vice-Chair McGee found the sentence fragment was an apparent typographical error, it was deficient and omitted crucial information as to the reasons for the assessment. Vice-Chair McGee commented as follows:

> [21] While this Tribunal has held that the sufficiency of the "medical and other reasons" issued in a notice pursuant to s. 44(5)[16] will turn on the unique facts of a given scenario, in principle, a strict requirement for detailed, clear, and meaningful reasons under s. 44(5) is consistent with the remedial consumer protection purpose of the *Schedule*.

Vice Chair McGee found that the insurer's Notices of Examination were "patently deficient" (para 25):

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[15] *BM v Unica Insurance Inc*, 2020 ONLAT 19-009381/AABS (CanLII). Retrieved at: <http://canlii.ca/t/j9wxk>

[16] O Reg 34/10: STATUTORY ACCIDENT BENEFITS SCHEDULE - EFFECTIVE SEPTEMBER 1, 2010, under *Insurance Act*, RSO 1990, c I.8 (Consolidation Period from July 3, 2020 to e-Laws currency date). Retrieved at: https://www.ontario.ca/laws/regulation/100034

> [27] *an insured person should not be expected to piece together "medical or other reasons" for an examination from disparate notices and correspondence, or, as Unica submits, to advise an insurer of deficiencies in those notices so they may be corrected.* ***The duty to give reasoned notice rests with the insurer.*** [emphasis added]

Vice-Chair McGee concluded that the "reasons" given were therefore "equivalent to no reason at all" (para 31) and excluded the impugned IE reports.

(d) Exception to the Incurred Requirement?

Section 3(8) of the *Schedule* provides an exception to the requirement that only "incurred" expenses will be payable by an insurer. In ***Pucci v The Wawanesa Mutual Insurance Company*, 2020 ONCA 265**[17], the relevant s. 3(8) read:

> If in a dispute to which sections 279 to 293 of the Act apply, a Court or arbitrator finds that an expense was not incurred because the insurer unreasonably withheld or delayed payment of a benefit in respect of the expense, the Court or arbitrator may, for the purpose of determining an insured person's entitlement to the benefit, deem the expense to have been incurred.[18]

The section reads similarly today with the references to "court" being replaced by "Licence Appeal Tribunal."

At issue in *Pucci* was whether the trial judge erred in awarding Ms. Pucci past household and attendant care expenses that had not been "incurred". The trial judge's Order would have required Wawanesa to pay about $18,000 for housekeeping and $270,000 for attendant care benefits regardless of the amount incurred by Ms. Pucci.

Wawanesa argued that Ms. Pucci was only entitled to those expenses that she *actually incurred.* Ms. Pucci argued that the exception at s. 3(8) applied as Wawanesa had unreasonably withheld payment of the benefits.

The Court of Appeal made clear that the trial judge was obliged to apply the definition of incurred at s. 3(7)(e) of the SABS[19]. The trial judge erroneously relied on case law that predated the definition.

The Court of Appeal then examined the applicability of the s. 3(8) exception. At trial, Ms. Pucci argued that Wawanesa acted unreasonably in withholding payments based exclusively on its expert's faulty causation opinion, which conflicted with the other expert

[17] *Pucci v The Wawanesa Mutual Insurance Company*, 2020 ONCA 265 (CanLII). Retrieved at: <http://canlii.ca/t/j6md9>,

[18] O Reg 34/10: STATUTORY ACCIDENT BENEFITS SCHEDULE - EFFECTIVE SEPTEMBER 1, 2010, under *Insurance Act*, RSO 1990, c I.8 (Historical version for the period June 1, 2013 to December 16, 2013). Retrieved at: https://www.ontario.ca/laws/regulation/100034/v4

[19] Ibid.

opinions on file and was inconsistent with the position Wawanesa had taken in the first two years of Ms. Pucci's claim.

The trial judge did not, however, address this submission. Instead, the trial judge focused on (1) the unfairness of the incurred definition and (2) the nine-month delay in Wawanesa providing its catastrophic assessment reports.

The Court of Appeal held that the unfairness of the incurred definition (i.e., in only reimbursing insureds who have the financial means to pay for benefits during disputes) is irrelevant:

> [42] The scheme is predicated on the repayment of expenses "incurred" within the very specific definition provided in s. 3(7)(e). The scheme does not create entitlement to payment based on need or a damages-like assessment of the insured's entitlements. Whatever the merits of the policy reflected in the current scheme, the operation of that policy in a given case does not assist in determining whether an insurer acted unreasonably in withholding payments.

The Court of Appeal also found little to no evidence to support a finding of unreasonableness based on the delay of the catastrophic reports. Counsel for Ms. Pucci made no such argument during trial. Further, the evidence indicated that some of the delay was due to Ms. Pucci being physically unable to complete the assessment and an assessor becoming ill. While it may have taken longer than it should have to complete the reports, no evidence was presented on this point.

The Court of Appeal then went on to consider Ms. Pucci's arguments regarding Wawanesa's reliance on its expert's questionable causation opinion. Unfortunately, there was no evidence regarding the steps Wawanesa took to critically review the expert report or the steps counsel for Ms. Pucci took to bring the inadequacies of the expert's evidence to Wawanesa's attention. The Court of Appeal determined that the record did not allow for a finding of fact about the reasonableness of Wawanesa's denial of coverage and ordered a new trial on this issue.

(e) When Does Use or Operation Start for Ride Share Services?

The SABS provide benefits when an insured is injured because of an automobile accident. Per s. 3(1), "accident" is defined as "an incident in which the use or operation of an automobile directly causes an impairment".[20] Two recent preliminary issue decisions addressed the definition of accident in the context of ride-share services.

[20] O Reg 34/10: STATUTORY ACCIDENT BENEFITS SCHEDULE - EFFECTIVE SEPTEMBER 1, 2010, under *Insurance Act*, RSO 1990, c I.8 (Consolidation Period from July 3, 2020 to e-Laws currency date). Retrieved at: https://www.ontario.ca/laws/regulation/100034

First is ***ML v Intact Insurance Company*, 2020 ONLAT 19-000607/AABS**[21]. The applicant was injured while waiting to be picked up by an Uber. The applicant did not know how the injury occurred. His last pre-accident memory was walking in the parking lot to meet the Uber. His next recollection was awakening to find himself lying on the ground injured. The applicant applied for accident benefits.

Adjudicator Grant found that the applicant did not meet his burden – the use or operation of the vehicle did not directly cause the impairment.

Adjudicator Grant reviewed the two-part test set out by the Court of Appeal in *Chisholm v. Liberty Mutual Group*, [2002] OJ No 3135[22], noting that both parts of the test (purpose and causation) must be established.

Because there was no evidence to establish that the Uber vehicle was present at the time of injury and the emergency records referenced a slip and fall as the mode of injury, the adjudicator concluded that the applicant did not satisfy the purpose prong of the test.

With respect to the causation prong, the adjudicator found that "***arranging for transportation via a ride-share application does not automatically commence the use or operation of a vehicle***" (para 21). Adjudicator Grant elaborated as follows:

> [32] In my view, the statutory accident benefits scheme was not intended to be so broadly interpreted or applied to the extent that arranging for a vehicle through a ridesharing application meets the definition of the "ordinary use or operation of a vehicle". A vehicle's use or operation is not established through arrangement via a ridesharing application, until that vehicle is present, and an insured is in the process of commencing or intending to engage in the ordinary use and operation of the vehicle. I find M.L.'s position to be a gross stretch of the definition where there is no evidence of the presence of a vehicle. Without the presence of a vehicle, neither the purpose or causation tests can be met. [emphasis added]

The second case is ***KP v Aviva General Insurance,* 2020 ONLAT 19-004361/AABS**[23], which involved a Lyft arrangement. The main difference between this and the prior case is that here, the vehicle was in fact present when the injury occurred. The applicant summoned the Lyft to take her to a medical appointment. The weather was poor – freezing rain, ice and snow accumulation. The Lyft arrived and parked less than half-way up the driveway requiring the applicant to traverse the icy driveway to enter the car. The applicant was concerned about falling and touched the hood of the car to stabilize herself. Before she was able to open the car door, she slipped and fell on the ice, breaking her left leg.

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[21] *ML v Intact Insurance Company*, 2020 ONLAT 19-000607/AABS (CanLII). Retrieved at: <http://canlii.ca/t/j5bsg>

[22] *Chisholm v Liberty Mutual Group*, [2002] OJ No 3135 (ONCA) (CanLII). Retrieved at: <http://canlii.ca/t/1cskk>

[23] *KP v Aviva General Insurance*, 2020 ONLAT 19-004361/AABS (Decision and Order) (CanLII). Retrieved at: <http://canlii.ca/t/j7w84>

Vice-Chair Mather found that the applicant met her burden in this case – the use or operation of the vehicle directly caused the impairment.

With respect to the purpose prong, Vice-Chair Mather held that "***the use and operation of the car began when the Lyft driver accepted her ride request and ended when the ride was cancelled by the driver. Included in this chain of events is the applicant's attempt to enter the car***." (para 16) The fact that the applicant had not yet opened the car door prior to her fall did not change the fact that she was attempting to enter the car, which was part of the normal use of the vehicle.

With respect to the causation prong, Vice-Chair Mather found there to be two direct causes of the incident – the icy, snowy conditions and the fact that the Lyft driver could not pull the car up to the entrance of the house. She found it reasonably foreseeable that if the applicant was required to walk down the driveway to the car, she may suffer injury.

Aviva applied for Reconsideration, which was also heard by Vice-Chair Mather (***KP v Aviva General Insurance,* 2020 ONLAT 19-004361/AABS**[24]) and denied. Vice-Chair Mather held that her initial finding, that attempting to enter a vehicle is a normal use of a vehicle, was all that was required for the applicant to meet the purpose prong of the test. Further, the distance the applicant was required to walk to the car was a foreseeable risk of injury, therefore meeting the causation prong of the test.

Seemingly in contrast to Vice-Chair Mather's prior statements about the use and operation of the vehicle commencing at the time the Lyft driver accepted the ride request, Vice Chair Mather stated:

> [52] In reaching my conclusion I gave no weight to the applicant's hearing submissions that the provisions of the recently new agreements between ride share providers and their riders have changed the landscape for liability for users of ridesharing services. The fact that that the vehicle was a Lyft vehicle makes no difference to my analysis of the facts. It does not matter whether the vehicle was a taxi, a Lyft car or a friend's vehicle. The fact that the Lyft driver parked less than halfway up the driveway requiring the applicant to navigate the driveway in a snow storm is a direct cause of the accident. [emphasis added]
>
> …
> [74] Aviva addresses this issue in its reconsideration reply submissions. My decision on this application placed no weight on either the terms of the Lyft Insurance policy with Aviva or the terms of use applicable to Lyft drivers and riders. I am not convinced by the applicant's submissions that terms of the automobile insurance policy for Lyft vehicles or the terms of use for Lyft drivers and riders affects the definition of accident for the purposes of the Schedule. [emphasis added]

Interestingly and to counter the Vice-Chair's finding that the distance the Lyft vehicle required the applicant to walk was a direct cause of the injury, Aviva argued that the

[24] *KP v Aviva General Insurance*, 2020 ONLAT 19-004361/AABS (Reconsideration) (CanLII). Retrieved at: <http://canlii.ca/t/j8z6z

applicant was not required to enter the vehicle – she could have cancelled the ride. Vice-Chair Mather found "no merit" to Aviva's argument stating that:

> [51] The fact that the applicant could have cancelled the ride may have some bearing in a tort action but does not change the fact that the Lyft driver stopped less than half way up the driveway requiring the applicant to navigate the driveway to get into the car.

Aviva's request for Reconsideration was denied. Vice-Chair Mather's original order was confirmed.

(f) Extraterritorial Priority Disputes

Section 268 of the *Insurance Act*[25] sets out the priority rules with respect to which insurer is liable to pay statutory accident benefits. The Court of Appeal in ***Travelers Insurance Company of Canada v CAA Insurance Company*, 2020 ONCA 382**[26] recently dealt with how, if at all, these rules apply to extraterritorial insurers.

This case involved a claimant who was catastrophically injured in an accident that occurred in Nunavut. She was driving a Nunavut-plated vehicle that was owned by her employer and covered by a Nunavut motor vehicle insurance policy issued by Travelers. The claimant was ordinarily resident in Ontario where she owned an Ontario-plated vehicle insured by CAA Insurance Company ("CAA") under the terms of the Ontario Standard Automobile Policy ("OAP").

Ontario SABS were more generous than Nunavut SABS. The claimant therefore applied for Ontario SABS from CAA. CAA pursued Travelers for reimbursement per s. 268 of the *Insurance Act*.

Travelers argued that it was prepared to pay what it was obliged to pay as SABS under the Nunavut policy (for which it received premiums at the Nunavut level), but not the higher Ontario SABS benefits. CAA succeeded in its claim against Travelers at arbitration and on the initial appeal. Travelers was ordered to reimburse CAA for the benefits CAA paid to the claimant, and to assume responsibility for paying the benefits into the future.

Travelers appealed to the Court of Appeal. The case turned on whether, with regards to the Nunavut policy and the collision having taken place in Nunavut, Travelers was to be considered an "Ontario insurer" for the purpose of the priority provisions of the Ontario *Insurance Act.*

Justice Lauwers, writing for the majority, referred to the Supreme Court of Canada decision in *Unifund Assurance Co of Canada v Insurance Corp. of British Columbia*, 2003

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[25] *Insurance Act*, RSO 1990, c I8. Retrieved at: https://www.ontario.ca/laws/statute/90i08#BK294

[26] *Travelers Insurance Company of Canada v CAA Insurance Company*, 2020 ONCA 382 (CanLII). Retrieved at: <http://canlii.ca/t/j893v>.

SCC 40[27], wherein the court made clear that Ontario's insurance laws do not have extraterritorial effect. As such, Ontario insurers cannot use the provisions of the Ontario *Insurance Act* to recover benefits they paid to their insureds from out-of-province insurers.

The court found that the arbitrator erred in what it termed a "bald assertion" that Travelers, as a signatory of the Power of Attorney and Undertaking ("PAU"), essentially becomes an Ontario insurer. The PAU's purpose is "to protect insureds". It is not about helping insurance companies recover compensation. Justice Lauwers elaborated as follows:

> [22] The use and application of the PAU in favour of insureds is context specific. If, for example, the claimant had driven the Nunavut vehicle into Ontario and had the accident here, Travelers would have had to provide her with statutory accident benefits at the Ontario level under the Nunavut policy. That is how the PAU is designed to work. But there is no basis for the arbitrator's assertion that the PAU operates to extend "loss transfer and priority obligations" between or among insurers otherwise liable to compensate an insured under the Ontario *Insurance Act*'s provisions.

Justice Lauwers also took issue with the arbitrator's finding that Travelers was an "Ontario insurer" simply because it was licenced to undertake automobile insurance in Ontario. His Honour held that,

> [25] … Mere licensing, or the presence of an office, does not convert these insurers into Ontario insurers for all purposes, nor does it make the Ontario *Insurance Act* the governing legislation for all automobile insurance policies they underwrite. Treating mere Ontario licensing as the sole reason to constitute an insurer as an "Ontario insurer" would give Ontario insurance legislation extraterritorial effect, which would be contrary to the essential holding in *Unifund*.

Ontario's s. 268 priority rules only apply if both insurers are subject to those rules (i.e., if they are both Ontario Insurers). The arbitrator and appeal judge erred in treating Travelers as an Ontario insurer and the Nunavut policy as an Ontario policy. This is contrary to the *Unifund* decision as it would constitute an extraterritorial application of Ontario law. It is also not justified under the PAU. The PAU does not have the effect of converting a Nunavut insurance contract into an Ontario insurance contract and does not require Travelers to pay Ontario SABS.

Travelers' appeal was allowed. Travelers was not liable under s. 268 of the Ontario *Insurance Act* to reimburse CAA for the benefits paid to the claimant, nor was it liable to assume responsibility for paying benefits into the future.

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[27] Unifund Assurance Co v Insurance Corp of British Columbia, 2003 SCC 40, [2003] 2 SCR 63 (CanLII). Retrieved at: <http://canlii.ca/t/51p8>

(g) Interim Benefits?

In ***TK v Allstate Insurance*, 2019 ONLAT 18-007113/AABS**[28], the claimant sought an order for interim benefits. Adjudicator Letourneau refused the request, stating that the Tribunal lacked jurisdiction to award substantive interim benefits pursuant to the *Licence Appeal Tribunal Act*, the *Statutory Accident Benefits Schedule* and *Insurance Act*. The adjudicator's decision was appealed to the Divisional Court (***Khan v Allstate Insurance Company of Canada*, 2020 ONSC 3578**[29]).

By the time the case was heard by the Divisional Court, the claimant settled his statutory accident benefit claim, making the issue of interim benefits moot. The claimant argued that the Divisional Court should still hear the appeal as it is a matter of public importance.

While the Divisional Court disagreed, it did leave the door open to consider an appropriate case on this issue in the future:

> [13] The question of the LAT's jurisdiction to grant interim benefits does not have a similar effect on all persons claiming accident benefits. Claimants can seek an expedited LAT hearing where they claim their need for benefits is urgent. Claimants can recoup their costs of interim benefits in the final adjudication of their claim. Only a subset of claimants may be faced with a failure of immediate material compensation arising from delay in LAT's claims process.
>
> [14] This is not to suggest that the issue of interim benefits is unimportant or affects very few people. There is no record before this court to support such conclusions. On the facts of the one case that is before us, there is no basis to conclude that the substance of the Adjudicator's interim ruling will create a situation where material harm could inevitably result to an identifiable group of people. A future case, which is not moot, may provide a better factual foundation for review in this court.

The Divisional Court therefore declined to exercise its discretion to hear the appeal. As such, the issue of interim benefits at the LAT remains *status quo*.

IV. Conclusion

That is the year in review. Despite the pandemic, it was not all bad.

On the positive side, the LAT put tremendous effort into modernizing its systems. Hearings may now be conducted by video conference and parties may schedule their own case conferences in certain cases. This opens new possibilities and cost-savings for stakeholders. Hopefully in person hearings will, however, continue to be available in appropriate cases once the pandemic resolves.

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[28] *TK v Allstate Insurance*, 2019 ONLAT 18-007113/AABS (CanLII). Retrived at: <http://canlii.ca/t/j1fb6>

[29] *Khan v Allstate Insurance Company of Canada*, 2020 ONSC 3578 (CanLII). Retrieved at: <http://canlii.ca/t/j854z>

In terms of decisions released, there were no major surprises. The inconsistencies continued. The main takeaways are as follows:

- Adjudicators are not bound by prior decisions.

- There exists a very high bar for special awards – the insurer's conduct must be excessive, imprudent, stubborn, inflexible, unyielding or immoderate. A special award will not be ordered simply because an insurer made an incorrect decision.

- There must be a permanent impairment to qualify for catastrophic designation per s. 3.1(1)2(iii) of the *Schedule*. It is not sufficient to register a score below 5 at a single point in time post-accident.

- *Tomec* does not extend the doctrine of discoverability to specified benefits (or maybe it does with the right set of facts?).

- Notices of Examination must provide detailed, clear and meaningful reasons. Deficient notices will result in the s. 44 reports being excluded from evidence.

- Expenses must be "incurred" to be reimbursable (although there is some hope for insureds that with the right set of facts, the s. 3(8) exception will apply eliminating the need for the expense to be incurred).

- Arranging transportation via a ride-share application does not automatically commence the use or operation of a vehicle. There must be some nexus between the vehicle and injury for the incident to qualify as an "accident" per the *Schedule*.

- Ontario's insurance laws do not have extraterritorial effect. The mere fact that insurers can issue insurance policies in multiple provinces does not result in the Ontario *Insurance Act* governing all the policies they underwrite. The statutory insurance scheme in the jurisdiction where the collision occurred ought not to be overlooked.

- Interim benefits continue to be unavailable at the LAT (although the door remains open for the Divisional Court to hear a more appropriate appeal in the future).