The Top Accident Benefits Decisions of 2014

Eric K. Grossman & Michelle Baik,
Zarek Taylor Grossman Hanrahan

The Top Accident Benefits Decisions of 2014

Eric K. Grossman and Michelle Baik, Zarek Taylor Grossman Hanrahan LLP

Contents

Right to Sue

In *Mader v South Easthope Mutual Insurance Company*,[1] the Court of Appeal for Ontario considered whether there is a right to bring an action in court on a stand alone basis for bad faith where the right to sue has been taken away pursuant to *Bill 15*.[2] The Court found that the Appellant, Ms. Mader, could not advance an action for bad faith.

Ms. Mader was involved in a motor vehicle accident on July 21, 2002. As a result of this accident, she applied for accident benefits pursuant to the *SABS*. She began receiving income replacement benefits on August 1, 2002 and received a notice on April 24, 2003 stating that the Respondent would terminate the Appellant's income replacement benefits as of May 6, 2003. Ms. Mader disagreed with the stoppage and requested a DAC (Designated Assessment Centre) assessment.

Before the DAC assessment, the appellant signed a Full and Final Release, which released the Respondent from any obligation to pay accident benefits to the Appellant, in exchange for $3,000. According to Ms. Mader, the Respondent's adjuster went to her apartment building and convinced her to sign the Full and Final Release. Ms. Mader alleged that, at the time, she felt that she had no other choice but to accept the settlement. According to the Respondent, Ms. Mader approached the Respondent first with a view to settling her claim.

On April 8, 2005, Ms. Mader issued a Statement of Claim seeking, among other reliefs, damages for conspiracy, mental distress, and breach of the duty to act in good faith. She alleged that the respondent breached its duty of good faith and caused her mental distress by unlawfully terminating her accident benefits.

Upon receipt of the Statement of Claim, the Respondent indicated in a letter that Ms. Mader had a statutory obligation to repay the settlement funds and that the Respondent was prepared to re-open the file and deal with the matter as if the settlement had not taken place. Ms. Mader did not respond, repay her settlement funds, or file for mediation.

The Court of Appeal found that Ms. Mader did not fulfill either of the statutory preconditions to the commencement of a court proceeding, namely repayment of the settlement funds and failed mediation. However, the Appellant's position was that the claims for mental distress, breach of the duty to act in good faith, and conspiracy, do not require a FSCO mediation before an action can be commenced. Ms. Mader's position was that her mental distress and bad faith claims were independent causes of action, which were not in respect of entitlement to or amounts of benefits. She argued that her claims resulted from the Respondent's denial of her procedural rights, rather than the denial of benefits.

[1] 2014 ONCA 714, [2014] OJ No 4906 [*Mader*].

[2] Fighting Fraud and Reducing Automobile Insurance Rates Act, 2014, SO 2014, c 9, Schedule 3 [Bill 15].

Although the Court left open the possibility of the breach of an insurer's duty of good faith or intentional infliction of mental distress constituting an independent cause of action,[3] it found that neither was a separate actionable wrong in this case.

In coming to this conclusion, the Court considered the reasoning in *Arsenault v Dumfries Mutual Insurance Co*,[4] where it was necessary for the Court to make a determination of whether bad faith claims were caught by section 279(1) of the *Insurance Act*,[5] which provides:

> Disputes in respect of any insured person's entitlement to statutory accident benefits or ***in respect of*** the amount of statutory accident benefits to which an insured person is entitled shall be resolved in accordance with sections 280 to 283 and the *Statutory Accident Benefits Schedule.* (emphasis added)

In *Arsenault*, Justice Abella determined that the use of the phrase "in respect of" is "probably the widest of any expression intended to convey some connection between two related subject matters." She found that "any and all disputes about an insurer's refusal to pay no-fault benefits, including disputes which allege the insurer's bad faith connection with that refusal"[6] were subject to the procedures and time limits in sections 280 to 283 of the *Insurance Act.* She further concluded that in any event, the appellant's claim was not an independent, actionable wrong and the appellant was merely attempting to "circumvent the mandatory requirements of the dispute resolution scheme in the *Insurance* Act through the guise of linguistic reformulation."[7]

Similarly, in *Mader*, the Court of Appeal found that the claims asserted by Ms. Mader all flowed from the denial of benefits, which she believes she was entitled to receive. The Court found this was precisely the type of claim contemplated for resolution by the procedures in sections 280 to 283 of the *Insurance Act*. As such, the Respondent's motion for summary judgment dismissing the Appellant's claim was upheld.

Attendant Care Benefits and "Incurred" Definition

a) Is Minimum Wage to be Read into Form 1?

In *Somerville and State Farm Mutual Automobile Insurance Company*,[8] Arbitrator Rogers ordered that payment to Mr. Somerville for attendant care services was to be made at the rates

[3] Citing *Whiten v Pilot Insurance Co*, 2002 SCC 18, [2002] 1 SCR 595 at para 82 [*Whiten*]; *Prinzo v Baycrest Centre for Geriatric Care*, (2002) 60 OR (3d) 474, 215 DLR (4th) 31 at paras 37-39, 64.

[4] (2002) 57 OR (3d) 625, [2002] OJ No 4 [*Arsenault*].

[5] RSO 1990, c I8, as amended.

[6] *Supra*, note 11 at para 17.

[7] *Ibid* at para 21.

[8] (11 September 2014), FSCO A12-006767 [*Somerville*].

provided in the prevailing Form 1 (Assessment of Attendant Care Needs) as prescribed in the *Statutory Accident Benefits Schedule—Effective September 1, 2010*,[9] rather than at the minimum wage set pursuant to the *Employment Standards Act*.[10]

Arbitrator Rogers explained that there are three categories of care: routine personal care assessed under Level 1, basic supervisory functions under Level 2, and complex health/care and hygiene functions under Level 3. He noted that the hourly rates for Level 1 and Level 3 care have always been higher than the minimum wage. However, the hourly rate for Level 2 care sometimes lagged behind the minimum wage.

As such, Mr. Somerville's position was that the minimum wage applied to payment for Level 2 care as opposed to the rates provided in the Form 1. He argued that the *Statutory Accident Benefits Schedule*[11] in force immediately preceding the *SABS*, which required Level 2 care to be paid at "the minimum hourly wage for the period to which the payment relates…" evidenced the intention that Level 2 care should be compensated at the minimum wage. In contrast, section 16(4) of the *SABS* governing Mr. Somerville's accident simply requires that the "monthly amount payable by the attendant care benefit shall be determined in accordance with Form 1".

Arbitrator Rogers found that Mr. Somerville's argument must fail because there is no reference at all to minimum wage in the *SABS* governing his accident. He also stated that the *SABS*, which is a specific statute dealing with the issue of payment for attendant care services, is paramount to the *Employment Standards Act*, which is a general statute dealing with the issue or rate of payment.

b) Form I Rates vs Actual Incurred Amounts

In *TTC and Estate of Reuben Marcus*,[12] Director's Delegate Blackman dismissed an appeal from Arbitrator Kelly's preliminary issue order[13] that the correct quantum of the attendant care benefits in dispute in this case was the amount set out in the Form 1, not the amount of actual economic loss of the insured.

The Form 1 was completed by Ms. Kennedy on March 20, 2011, where it was assessed that Mr. Marcus required 24-hour attendant care per day at a monthly cost of $6,569.29. As such, Mr. D.

---

[9] O Reg 34/10 [*SABS*].

[10] SO 2000, c 41, as amended.

[11] *Statutory Accident Benefits Schedule – Accidents after December 31, 1993 and before November 1, 1996*, O Reg 776/93, as amended [*Old Schedule*].

[12] *Toronto Transit Commission Insurance Company Limited and The Estate of Reuben Marcus, Deceased, by its Executor, Amy Marcus* (19 September 2014), FSCO P14-00005 [*Marcus*].

[13] *Toronto Transit Commission Insurance Company Limited and The Estate of Reuben Marcus* (13 January 2014), FSCO A12-006408.

Caldito, R.N., was hired under a written contract to provide attendant care services to the claimant starting April 1, 2011.

Mr. Caldito's $1,820 base monthly wage was subject to overtime, but Mr. Marcus was receiving $3,000 per month for the services, which is $1,180 per month more than the claimant's actual economic loss. The Insurer argued that to accept that Mr. Marcus is entitled to an attendant care benefit of $6,000 per month (if he is found to have been catastrophically impaired) results in a windfall of $4,180 more than what was paid out to the caregiver by the claimant. The Appellant Insurer also argued that if the claimant actually needed $6,566.29 worth of attendant care services per month, the care provider would have been providing that level of care and the amount would have been paid.

Director's Delegate Blackman agreed with the comments of the Court in *Henry v Gore Mutual Insurance Company*[14] that in the case of non-professional care providers, the attendant care benefit payable "shall not exceed the amount of economic loss sustained by the attendant care provider during the period while and as a direct result of providing the attendant care."

In the case of professional care providers, Director's Delegate Blackman considered and agreed with the decision in *Henry*, that clause 3(7)(e) of the *SABS* that defines "incurred" is an entitlement threshold. Subsection 19(1) outlines additional entitlement thresholds that the attendant care expense must be reasonable, necessary, and "as a result of the accident." He also reiterated that subsection 19(2) makes clear that, once entitlement is determined, the amount of the benefit is based on the insured's need for care, which is subject to the maximums in subsection 19(3). He stated that "[t]hese entitlement requirements modify and apply to the expense. The attendant care benefit payable, however, is not necessarily the equivalent of the expense. Nor is the attendant care benefit payable necessarily the equivalent of the Form 1 amount."

In this case, Mr. Caldito was a professional care provider. His contract provided for a wage of $1,820 a month. However, his remuneration was not limited to an hourly wage and restricted hours. He was also provided with a private room/bathroom and board in the employment contract for $280 a month. The contract was open-ended regarding overtime, CPP and EI were paid, and severance of $7,460 was paid in 2013. For his 26 months of service, the Claimant stated that Mr. Caldito was paid $84,139 inclusive of severance pay. However, the Insurer paid Mr. Marcus $35,000 for attendant care services.

Director's Delegate Blackman found that this case involved a mix of monetary arrangements nestling within subclause 3(7)(e)(ii) of the *SABS* to meet the need for care identified by Ms. Kennedy in her Form 1 dated March 20, 2011. He stated that this was consistent with balancing the concept of indemnification with protecting seriously injured claimants where there is a statutory obligation to pay. Accordingly, he found that insurers are no more entitled to a windfall than insured persons. As such, he confirmed Arbitrator Kelly's decision that the quantum of the

[14] 2013 ONCA 480, 116 OR (3d) 701 [*Henry*].

attendant care benefit in dispute should be paid according to the figure set out in the Form 1, subject to monetary limits of subsection 19(3) applicable to non-catastrophic and catastrophic cases.

c) Is a full-time caregiving spouse someone who provided care "in the course of the employment, occupation, or profession"?

In *Josey and Primmum Insurance Co*,[15] Arbitrator Fadel considered whether the applicant, Mr. Josey, was entitled to attendant care benefits claimed. The parties agreed that the applicant required attendant care as a result of the accident. However, Mr. Josey received attendant care services from his spouse. Mr. Josey argued that the attendant care expense was "incurred" as his spouse's capacity as a full-time caregiver to their children constituted providing care in the course of her "employment, occupation, or profession", pursuant to s. 3(7)(e)(iii)(A) of the *SABS*. The applicant accordingly claimed that he was entitled to attendant care benefits without having to prove economic loss. Arbitrator Fadel did not agree with the applicant and found that he was not entitled to the attendant care benefits claimed.

Arbitrator Fadel observed that the *SABS* signified a significant shift in how attendant care benefits are payable compared to its predecessor. The *SABS* now requires a non-professional attendant care provider to show that they have sustained an economic loss as a result of providing the services. In the case of services provided by a professional attendant care provider, it must have been provided in the course of their "employment, occupation, or profession", which Arbitrator Fadel noted would imply that remuneration is provided for that service. He found that the wording of s. 3(7)(e)(iii)(A) is "clear and the intention was that the attendant care services be provided by a professional in the health care industry." As such, Arbitrator Fadel concluded that an unpaid stay-at-home parent providing care to their children did not meet the definition of "incurred".

d) Course of "employment, occupation, or profession" and services provided indirectly

In *Shawnoo v Certas Direct Insurance Company*,[16] Justice Garson considered three issues. The first was whether the Applicant's friend, a trained certified child youth worker ("CYW") provided attendant care services in the course of the "employment, occupation or profession" in which she would ordinarily have been engaged, but for the accident. The second issue considered whether the Applicant's mother, a trained and certified personal support worker ("PSW") who was not working in a paid position as a PSW, qualified as one who provided attendant care in the course of the "employment occupation or profession." Finally, the Court considered whether attendant care services can be provided remotely by way of electronic means, including telephone calls, emails, FaceTime, and text messaging.

[15] (31 October 2014), FSCO A13-005768

[16] 2014 ONSC 7014 [*Shawnoo*].

In assessing the first issue regarding the Applicant's friend, a CYW, the Court found that her services were not provided in the course of her employment, occupation, or profession in which she would ordinarily have been engaged, but for the accident. Justice Garson explained that her profession, in which she continued to work during regular workdays, entailed providing supervision and support for troubled youth. He observed that the CYW was the roommate of the Applicant and that she neither trained in the field of healthcare nor had any prior work history or experience in the same. Although her services were valuable for the Applicant, Justice Garson was not satisfied that she provided such services in the course of the employment in which she would ordinarily have been engaged in, but for the accident.

With regards to whether the Applicant's mother, a PSW who was not working in her capacity as a PSW, the Court found that she too was not a professional care provider. Although the Applicant's mother was trained as a healthcare aide and had been employed as such in the past, she was not employed for remuneration in that capacity since 2006. Immediately prior to the accident, she was in receipt of Ontario Works. In 2009, she began providing support in that capacity to a relative. However, there was no evidence that she was actively seeking work in her capacity as a PSW. Accordingly, he was not satisfied that the Applicant's mother would ordinarily have been engaged in healthcare services. Justice Garson found:

> Applying a broad interpretation to the legislative provisions in question and accepting that the goal of the legislation is to reduce hardship on accident victims, I am still unable to conclude that CB [the Applicant's mother] provided her services "in the course of the employment occupation or profession she would ordinarily have been engaged in, but for the accident". (emphasis added)

In addition, in reference to the recent amendment to the *SABS* on February 1, 2014, Justice Garson agreed with *Josey* in concluding that section 3(7)(e)(iii)(A) refers to a "person who is trained in and/or working in the health care industry for remuneration." As such, he concluded that she must be excluded from receiving *SABS* without showing an economic loss.

Finally, Justice Garson concluded that attendant care services could be provided via electronic sources. He noted that attendant care is allocated to electronic services in the Form 1 under the section regarding supervisory "custodial care" due to changes in behaviour. Thus, he explained the question that should be considered is whether "custodial care required the personal presence of the attendant vis-à-vis the injured person." He found that the meaning of custodial care on the facts of this case was "whether the provision of such care is protective of the person and allows the care provider to look after the person." Given this definition, Justice Garson stated that custodial care does not require the provider to be in the immediate physical presence of the Applicant. Thus, he found:

> In all of the circumstances before me, including the age of MS [the Applicant], the proliferation of cell phones and texting as a way of effectively communicating, the accepted position of Certas on paying for such expenses in relation to Cydney Simpson, the nature of the illness of MS and assorted treatment requirements, I conclude that attendant care services may be "provided" in the form of phone calls, e-mails, texting, FaceTime and other similar electronic means, for the purposes of SABS-2010. (emphasis added)

Transitional Application of "Incurred" Definition

In *Rajbhai and State Farm Mutual Automobile Insurance Company*,[17] the Applicant was injured in a motor vehicle accident on September 25, 2010. The issue before Arbitrator Mutch was whether proof of economic loss, pursuant to section 3(7)(e) of the *SABS*, was required in order to claim for attendant care benefits under a transitional policy. He found that proof of economic loss was required.

Arbitrator Mutch referred to section 2 of the *SABS* dealing with transitional policies and found that, with the exception of section 68, the benefits set out in the *SABS* must be provided under every contract evidenced by a motor vehicle liability policy relating to accidents occurring on or after September 1, 2010. Section 68 of the *SABS* specifically limited the continuation of monetary limits set out in the previous legislation for transitional policies. Arbitrator Mutch found that "the Legislature should not retroactively alter substantive rights under a motor vehicle liability policy. At the same time, it circumvents the counter argument that those rights do not vest until the insured has been involved in a motor vehicle accident." He further found that the *SABS* "does not identify the requirements for claiming attendant care benefits as a protected, or preserved provision." Arbitrator Mutch concluded that the Applicant's rights only vested on September 25, 2010, the date of the accident. As such, it was subject to the requirements of section 3(7)(e), pursuant to the *SABS*.

In *Zaya and State Farm Mutual Automobile Insurance Company*,[18] the Applicant was injured in a motor vehicle accident on October 7, 2010. As such, the parties agreed that the Applicant's automobile policy qualified as a "transitional policy" under the *SABS*, and was still able to claim for caregiver and housekeeping benefits. The issue before Arbitrator Pressman was whether the Applicant's claims for caregiver and housekeeping benefits must meet the new "incurred" definition pursuant to the *SABS*.

Arbitrator Pressman found that the Applicant was required to comply with the new definition of "incurred" expense pursuant to section 3(7)(e) of the *SABS*. In coming to this conclusion, she referred to sections 2 and 68 of the *SABS* dealing with transitional policies. Section 2 states, as follows:

> 2(1) Except as otherwise provided in section 68, the benefits set out in this Regulation shall be provided under every contract evidenced by a motor vehicle liability policy in respect of accidents occurring on or after September 1, 2010.

Arbitrator Pressman found that the language in section 2(1) was unambiguous and clear – "if a motor vehicle accident occurs on or after September 1, 2010, then the statutory accident benefits provided are subject to the *New Schedule*, with the only exception outlined in section 68", which relates to the availability of specific benefits (including caregiver and housekeeping) for

[17] (27 October 2014), FSCO A13-003578.

[18] (28 November 2014), FSCO A12-005753.

claimants involved in an accident after September 1, 2010, who have transitional policies. As a result, it was found that the Applicant could still claim caregiver and housekeeping benefits, but the claims would be subject to the new "incurred" definition of the *SABS*.

Catastrophic Impairment & Whole Person Impairment Assessment

The issue before Arbitrator Huberman in *Taylor and Pembridge Insurance Company of Canada*[19] was whether the Applicant sustained a catastrophic impairment as a result of a motor vehicle accident on September 10, 2009. In considering the expert evidence by Dr. Harold Becker and Dr. Howard Platnick concerning the Applicant's WPI (Whole Person Impairment) ratings, Arbitrator Huberman assessed the shortfalls of the use of a range of impairment percentages versus the selection of a specific number.

Dr. Becker, who assessed a rating of 37-62% WPI for Ms. Taylor's physical impairments, was very critical of Dr. Platnick's choice of a specific number, 26%, within the given ranges in the *AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition* (the "*Guides*"). He stated "in most situations, specific numbers do not make sense from a clinical point of view as a patient's condition can fluctuate on a day-to-day basis." In his opinion, the ultimate decision as to catastrophic impairment based on WPI ratings remains with the Arbitrator.

However, Arbitrator Huberman found that Dr. Platnick's approach was comprehensive, thorough, and thoughtful. He also concluded that Dr. Becker's rating of 37-62% WPI was extremely problematic as the range provided a "dual meaning" and as such, was not persuasive. "Part of the range, 37-54% WPI, means that Ms. Taylor does not meet the catastrophic threshold for physical impairments; and the remaining part of this range, 55-62% WPI, means that Ms. Taylor meets or exceeds the catastrophic threshold." Arbitrator Huberman stated that the range makes the arbitrator's adjudicative task even more difficult and makes it challenging for Ms. Taylor to satisfy her burden of proof that she meets the 55% WPI threshold for catastrophic impairment. As such, he noted that from the perspective of an adjudicator, the range was of no assistance in determining the central issue in the case.

Based on the evidence, Arbitrator Huberman found that Ms. Taylor's WPI for her combined physical impairments was 26% as assessed by Dr. Platnick.

In *obiter dictum* of his decision in *Moser and Guarantee Company of North America*,[20] Arbitrator Lee grappled with whether it was possible to narrow the range of impairment percentages provided by Dr. Lisa Becker in assessing the Applicant's WPI.

Dr. L. Becker's position was that it was not possible to narrow the range as the *Guides* themselves offered no way to select a number within a range. She noted various examples where the evaluator was directed by the *Guides* to choose the higher number when a range existed.

[19] (11 June 2014), FSCO A12-004886.

[20] (26 September 2014), FSCO A13-000812.

Upon analysis of the examples referred to by Dr. L. Becker, Arbitrator Lee stated he did not support her argument. For instance, Dr. L. Becker suggested that the last paragraph in the right hand column of section 3.2i in the *Guides*, "Diagnosis-based Estimates", was an example of a *Guides*-based direction to select a higher impairment rating when presented with a range. Arbitrator Lee found that the example did not direct or suggest this contention as it was clear that the *Guides* were giving direction "when *two* different methods of assessing an impairment are being used, in this case, the rating for arthritic degeneration *or* the rating obtained by using ranges of motion." He further observed that the language in section 3.2i of the *Guides* suggests that an evaluator may narrow a range through the use of a clinical evaluation. "For most diagnosis-based estimates, the ranges of impairment are broad, and the estimate will depend on *clinical manifestations*."

Arbitrator Lee concluded that "in many cases, it was indeed appropriate and possible to derive a more precise rating from a wide range of possible values listed within a category in the *Guides*." He referred to numerous references in the *Guides* themselves setting out the meticulous methodology to be used when rating impairments, which suggests that wide impairment ranges may be narrowed. The following were listed as examples of directions in the *Guides* to be as specific as clinically possible:

> "The impairment estimate or rating is a *simple* number." [not a range]
>
> "A final estimated whole-person impairment percent, … may be rounded to the nearer of the two nearest values ending in 0 or 5." There is no suggestion here that a WPI should be expressed as a range of values as wide as 1-14.
>
> "A proper medical evaluation accurately documents the individual's *clinical* status." This suggests and underlines the importance of the evaluator's clinical observation and diagnosis.
>
> "The second step in assessing the impairment is analyzing the history and the clinical and laboratory findings to determine the nature and *extent* of the impairment or dysfunction …"
>
> Under Rules for Evaluations: "The physician must utilize the entire gamut of *clinical skill and judgment* in assessing whether or not the results of measurements or tests are plausible and relate to the impairment being evaluated." This underlines once again the importance of clinical judgment and skill on the part of the evaluator.
>
> "If in spite of an observation or test result the medical evidence appears not be of sufficient weight to verify that an impairment of a certain magnitude exists, the physician should*modify the impairment estimate accordingly* …"
>
> "An impairment percentage derived by means of the *Guides* is intended, among other purposes, to represent an informed estimate of

> the degree to which an individual's capacity to carry out daily activities has been diminished."
> "The physician's *judgment and his or her experience, training, skill, and thoroughness in examining* the patient and applying the findings to *Guides* criteria will be factors in estimating the *degree* of the patient's impairment."
>
> "The physician performing an impairment evaluation must provide *more than a number or percentage*. The physician should provide as comprehensive a picture of the patient as possible using the Report of Medical evaluation Form as an outline." [italics mine]

Arbitrator Lee found that these statements in the *Guides* suggest "that clinical observation, training, judgment, experience, skill, and thoroughness of evaluation should be used to derive as precise a rating for an impairment as possible." As a result, he rejected Dr. L. Becker's and Dr. H. Becker's opinion that such ranges may not be narrowed by an evaluator.

Arguably, these cases may have future implications on the weight given to expert evidence where a range of impairment percentages is used rather than the selection of a specific number. While appeals have been launched of both decisions, *Taylor* has settled before an appeal could be heard.

Speaking to Experts

In *Lacroix v Federation Insurance Company of Canada*,[21] Justice Labrosse considered whether counsel for the Defendants is entitled to discuss the subject matter of the action with certain medical experts in advance of being called as witnesses for Trial.

In determining this issue, Justice Labrosse found that the purpose of section 42 of the *SABS* is to allow the insurer to choose an examiner to assess the insured person and prepare a report. In preparation for litigation, the Court concluded that no further consent is required from the Plaintiff for the Defendants' counsel to meet with the examiners, discuss the report, and relevant health information. Justice Labrosse further stated that Defendants' counsel was entitled to prepare the examiner for "the rigors of cross-examination" by refreshing their memory and discussing health information of the insured that were obtained following the report. Counsel could also seek assistance from the examiner in reviewing reply reports. Justice Labrosse found that it would be prejudicial to prevent the Defendants from doing so.

[21] 2014 ONSC 6002, [2014] OJ No 4857 [*Lacroix*].

Summary Judgment in AB Cases

a) Summary judgment and non-earner benefits

In *Willoughby v Dominion of Canada General Insurance Company*,[22] the Defendants brought a motion for summary judgment pursuant to Rule 20 of the *Rules of Civil Procedure*[23] seeking dismissal of the action on the basis that the Plaintiff did not satisfy the test for non-earner benefits (NEBs). Justice Broad held that there were genuine issues requiring a trial.

At the time of the accident, on July 8, 2004, the Plaintiff was employed as a cook in a restaurant. Approximately four months after the accident, the Plaintiff returned to work in the restaurant on modified duties and returned to full-time regular duties three to four months after that. As such, the Plaintiff received IRBs from July 14, 2004 to October 28, 2004. When the benefit was discontinued, she brought an action claiming entitlement to IRBs and was examined for discovery in that action. This action was settled, following which the Plaintiff claimed for NEBs in August 2009.

It is important to note that Dominion did not rely on the fact that the Plaintiff was employed at the time of the action and received IRBs. Justice Broad reiterated the decision in *Galdamez v Allstate Insurance Company of Canada*,[24] where the Court of Appeal held that "a claimant's status as an employed person does not, by itself, establish that the claimant is ineligible for non-earner benefits."

Instead, the insurer led evidence that the only evidence produced by the Plaintiff suggests that she does not meet the test for NEBs in that she continued to engage in substantially all of her pre-accident activities. Dominion argued that there was an apparent discrepancy between the Plaintiff's first and second examinations for discovery. On the first examination (with respect to her IRB claim), the Plaintiff stated that she was not going to return to school and planning on working instead. On her examination relating to her NEB claim, when asked what her plans were at the end of her first year at Mohawk College, she stated that she intended on returning to school. Dominion argued that an adverse finding against the Plaintiff on her credibility was justified so as to support the granting of summary judgment.

In order to assess the evidence before the Court, Justice Broad relied on the direction provided by the Supreme Court of Canada in *Hryniak v Mauldin*[25], where Justice Karakatsanis spoke to the appropriate use of the new fact-finding powers under Rules 20.04(2.1) and (2.2) at para. 66, as follows:

---

[22] 2014 ONSC 1135, [2014] OJ No 2079 [*Willoughby*].

[23] RRO 1990, Reg 194, as amended [*Rules*].

[24] 2012 ONCA 508, 111 OR (3d) 321 [*Galdamez*].

[25] 2014 SCC 7, [2014] 1 SCR 87 [*Hryniak*].

> On a motion for summary judgment under Rule 20.04, the judge should first determine if there is a genuine issue requiring trial based only on the evidence before her, without using the new fact-finding powers. There will be no genuine issue requiring a trial if the summary judgment process provides her with the evidence required to fairly and justly adjudicate the dispute and is a timely, affordable and proportionate procedure, under Rule 20.04(2)(a). If there appears to be a genuine issue requiring a trial, she should then determine if the need for a trial can be avoided by using the new powers under Rules 20.04(2.1) and (2.2). She may, at her discretion, use those powers, provided that their use is not against the interest of justice. Their use will not be against the interest of justice if they will lead to a fair and just result and will serve the goals of timeliness, affordability and proportionality in light of the litigation as a whole.

Justice Broad was not prepared to make an adverse finding against the Plaintiff on her credibility upon reviewing her testimony at her examinations for discovery. He further found that he was not satisfied that he was able to make the necessary findings of fact and to apply the law to those facts, in order to make a fair and just adjudication, based upon the evidence before him.

Relying on *Heath v Economical Mutual Insurance Company*,[26] Justice Broad noted:

> …the question of whether the injuries sustained by the plaintiff's accident prevented her from engaging in substantially all of the activities in which she ordinarily engaged before the accident is to be viewed from a "qualitative perspective" requiring the relevant activities to be viewed as a whole, with the manner in which each activity is performed and quality of performance post-accident to be considered.

Further, he found that given that the primary factor allegedly preventing the insured from engaging in her former activities is pain, the question is not whether the Plaintiff can physically do these activities, but "whether the degree of pain experienced, either at the time, or subsequent to the activity, is such that the individual is practically prevented from engaging in those activities."

Justice Broad concluded that the evidence led by Dominion on the motion for summary judgment fell well short of what was necessary to make findings of fact on the issues and to apply those facts to the legal framework provided in *Heath.* He found that a trial was required to make a fair and just adjudication of the issues in the case.

Justice Broad expressly added that this determination should not stand for the proposition that an action for NEBs will never be amenable to a motion for summary judgment.

[26] 2009 ONCA 391, [2009] 95 OR (3d) 785 [*Heath*].

b) Summary judgment and limitation period

In *Compton v State Farm Insurance Company of Canada*,[27] the Defendant, State Farm, appealed a motion for summary judgment for a determination that the Plaintiff's claim for an income replacement benefit ("IRBs") was statutorily barred by the limitation period.

As a result of a motor vehicle accident on September 30, 2003, the Plaintiff claimed and subsequently received payments for income replacement benefits on or about January 26, 2006 after the Plaintiff had stopped working. On September 13, 2007, following a physiatry assessment indicating that the Plaintiff no longer suffered a substantial inability to perform his pre-accident employment, State Farm advised the Plaintiff that he was no longer entitled to IRBs effective September 20, 2007. The Plaintiff filed an Application for Mediation on October 3, 2007 and a Report of Mediator was issued on February 28, 2008. No further steps were taken in response to State Farm's denial following February 2008.

Justice Thomas found that the motions judge erred in law in concluding that there was a genuine issue requiring a trial. In citing *Wadhwani v State Farm Mutual Insurance Company*,[28] he found the Court of Appeal clearly removed the ability to apply the "discoverability" principle into the analysis of section 281.1 of the *Insurance Act* regarding limitation periods. The Court found that "if an insured after the initial 104 week period becomes entirely unable to work because of an accident-related injury, he or she cannot reactivate the limitation period by making a fresh claim for further benefits." Accordingly, the summary judgment was granted dismissing the Plaintiff's claim.

In *Roger v The Personal Insurance Company of Canada*,[29] the Plaintiff brought a motion for partial summary judgment under rule 20 of the *Rules of Civil Procedure* seeking a determination that the action was not statute-barred as a result of the limitation period in s.281.1 of the *Insurance Act.*

The Plaintiff applied for statutory accident benefits following a motor vehicle accident on August 4, 2006, which included an OCF-3 form signed by her physician. The Defendant began to pay income replacement benefits to the Plaintiff as of August 9, 2006. Post 104 weeks, and without obtaining a new disability certificate from the Plaintiff, the Defendant arranged for the Plaintiff to be assessed by an occupational therapist, orthopaedic surgeon, and a neurologist to determine whether the Plaintiff met the test for the continuation of her IRBs. Subsequently, the Plaintiff had undergone further examination by Dr. Judge, a neuropsychologist, at the request of the Defendant on April 22, 2009. By way of an Explanation of Benefits sent to the Plaintiff by the Defendant on July 14, 2009, the Defendant terminated her benefits stating the Insurer

[27] 2014 ONSC 2260, [2014] OJ No 1868 [*Compton*].

[28] 2013 ONCA 662, [2013] OJ No 4972 [*Wadhwani*].

[29] 2014 ONSC 1964, [2014] OJ No 1575 [*Roger*].

Examination report by Dr. Judge indicated that she did not meet the test to receive post-104 week IRBs.

On the issue of summary judgment, Justice Aitken stated that this case can properly be considered on a motion for partial summary judgment under rule 20.04(2)(a). She found that in this case, the "motion for summary judgment is a proportionate, more expeditious, and less expensive means than a trial to achieve a just result." The evidence is clearly and fairly set out in an affidavit and other exhibits that allow the court to make the necessary determinations of fact. She also noted that counsel have the opportunity to fully argue the legal issues on the summary judgment motion. Thus, the Court is required to apply the law to the facts.

Justice Aitken found that the most egregious non-compliance by the Defendant with the requirements pursuant to sections 37 and 42 of the *SABS* was the Defendant's failure to request that the Plaintiff submit a new disability certificate prior to requiring the Plaintiff to submit to insurer's examinations. She concluded that the language used in section 37(1)(a) of the *SABS* "makes it entirely plausible that requesting an up to date disability certificate is a mandatory requirement which acts as a precondition to an insurer terminating benefits under this section." The second serious non-compliance with sections 37 and 42 was that the Defendant failed to send Dr. Judge's report to the health practitioner who provided the disability certificate. This was not done as a new disability certificate was not requested. As a result, Justice Aitken found that, as per *Smith v Co-operators General Insurance Co*,[30] "[s]ince a proper refusal was not given, and since the limitation period under s.281(5) [now s.281.1(1)] of the *Insurance Act* only begins to run upon a refusal, that limitation period was not triggered by the notice sent..." Justice Aitken also stated:

> Smith stands for the general proposition that, where an insurer does not comply with the clear and unequivocal procedural requirements set out in ss. 37 and 42 of the *SABS* in regard to preconditions which, if ignored, place the insured at a disadvantage, the insurer cannot rely on its purported termination of benefits as triggering the commencement of the limitation period under s. 281.1(1).

As a result, she found that proper notice of termination of benefits was not given to the Plaintiff due to the Defendant's non-compliance with sections 37(1)(a) and 37(5). Thus, the limitation period did not start to run.

Priority Cases

a) Failure to provide Claimant with Notice to Applicant of Dispute Between Insurers

The issue of whether failing to provide the Claimant with the Notice to Applicant of Dispute Between Insurers, as required by section 4 of Ontario Regulation 283/95 of the *Insurance Act*,

[30] 2002 SCC 30, [2002] 2 SCR 129 [*Smith*].

precludes one from advancing a priority dispute against another insurer was addressed for the first time in *Belair Direct Insurance Company v Security National Insurance Company*.[31]

In this case, Belair provided notice to Security National of its intention to dispute its obligation to pay benefits to the Claimant within the prescribed 90-day period. However, Belair failed to provide a copy of this notice to the Claimant, as stipulated in section 4. Section 4 states that an insurer giving notice to another insurer pursuant to section 3 "shall" also give notice to the insured person in the prescribed form. Both parties agreed that this creates a mandatory obligation. However, Belair argued that it should not be precluded from advancing its dispute.

Arbitrator Novick found that the requirements in the regulation must be applied strictly, despite the fact that no prejudice has been suffered. She considered the regulation and found that it was "clearly drafted with the potential participation of claimants in mind." Five of the eleven sections in the regulation address the rights and obligations of the claimant. In addition, the prescribed form for providing notice, which is titled Notice to Applicant of Dispute Between Insurers, is detailed and clearly directed to the insured person. She found that the drafters of the regulation clearly intended to give special consideration to the rights of the insured person in the process.

Arbitrator Norvick also considered whether the she should grant relief from forfeiture. In citing *Kingsway General Insurance v West Wawanosh Insurance Co*,[32] Arbitrator Norvick found that courts do not have a "general discretion to relieve against forfeiture where the regulation in issue explicitly provides for certain circumstances." She reiterated that the parties involved in priority disputes are presumed to be sophisticated litigants who deal with disputes under the regulation on a daily basis, which requires strict adherence to procedural requirements of the regulation. As such, she found that granting relief against forfeiture was not justified.

b) Are insurers other than "motor vehicle liability insurers" required to respond to a claim for SABS?

In *Zurich Insurance Company v Chubb Insurance Company*,[33] the Applicant rented a vehicle from "Wheels 4 Rent", which was insured under a motor vehicle liability policy issued by Zurich. Chubb issued an accident policy to Wheels 4 Rent that did not include any coverage for liability to others as a result of a motor vehicle accident. It only provided optional death and dismemberment insurance to the customer of Wheels 4 Rent. The Applicant did not purchase this optional coverage. Although the Applicant made an initial claim to Chubb, after Chubb refused to pay, Zurich ultimately began payment of the *SABS*.

[31] (unreported decision of Arbitrator Norvick) (11 April 2014).

[32] (2002) 58 OR 3d 251, [2002] OJ No 528 [*Kingsway*].

[33] 2014 ONCA 400, 120 OR (3d) 161, leave to appeal to SCC granted [*Zurich*].

At first instance, Arbitrator Tessis found that Chubb was not an auto insurer in the circumstances, and that it owed no duty to comply with the priority regulation. His decision was reversed on appeal by Justice Goldstein. After leave was granted to further appeal, the Court of Appeal found that there was no element of the optional insurance that insured against liability to others arising out of property damage or injury caused by an automobile. The Court noted that "[t]he content of "motor vehicle liability policies" is highly regulated. These policies must provide for payment of SABS, and a statutory minimum amount of liability coverage." Although *SABS* are deemed to be included in motor vehicle liability policies pursuant to section 268, these benefits are not incorporated into insurance policies that do not qualify as motor vehicle liability policies. The Chubb policy failed to encompass any of these characteristics. As a result, the Court of Appeal concluded that Chubb was not required to respond to the Applicant's claim for accident benefits and was excluded from the obligation to pay first and dispute later. However, in a strongly written dissent, Justice Juriansz found that the *Insurance Act* does not create a distinction for non-motor vehicle liability insurers, and as such, Chubb should be obliged to conform to the priority regulation.

Leave to appeal the Court of Appeal's decision was granted by the Supreme Court of Canada, and this issue is to be heard in Ottawa on April 16, 2015.

Appendix

1. *Arsenault v Dumfries Mutual Insurance Co* (2002) 57 OR (3d) 625, [2002] OJ No 4.

2. *Belair Direct Insurance Company v Security National Insurance Company* (unreported decision of Arbitrator Norvick) (11 April 2014).

3. *Compton v State Farm Insurance Company of Canada*, 2014 ONSC 2260, [2014] OJ No 1868.

4. *Galdamez v Allstate Insurance Company of Canada*, 2012 ONCA 508, 111 OR (3d) 321.

5. *Heath v Economical Mutual Insurance Company*, 2009 ONCA 391, [2009] 95 OR (3d) 785.

6. *Henry v Gore Mutual Insurance Company*, 2013 ONCA 480, 116 OR (3d) 701.

7. *Hryniak v Mauldin*, 2014 SCC 7, [2014] 1 SCR 87.

8. *Josey and Primmum Insurance Co* (31 October 2014), FSCO A13-005768.

9. *Kingsway General Insurance v West Wawanosh Insurance Co*, (2002) 58 OR 3d 251, [2002] OJ No 528.

10. *Lacroix v Federation Insurance Company of Canada*, 2014 ONSC 6002, [2014] OJ No 4857.

11. *Liberty Mutual Insurance Company and Persofsky* (31 January 2003), FSCO P00-00041.

12. *Mader v South Easthope Mutual Insurance Company*, 2014 ONCA 714, [2014] OJ No 4906.

13. *Moser and Guarantee Company of North America* (26 September 2014), FSCO A13-000812.

14. *Prinzo v Baycrest Centre for Geriatric Care*, (2002) 60 OR (3d) 474, 215 DLR (4th) 31.

15. *Rajbhai and State Farm Mutual Automobile Insurance Company* (27 October 2014), FSCO A13-003578.

16. *Roger v Personal Insurance Company of Canada*, 2014 ONSC 1964, [2014] OJ No 1575.

17. Shawnoo v Certas Direct Insurance Company, 2014 ONSC 7014.

18. *Smith v Co-operators General Insurance Co*, 2002 SCC 30, [2002] 2 SCR 129.

19. *Somerville and State Farm Mutual Automobile Insurance Company* (11 September 2014), FSCO A12-006767.

20. *Taylor and Pembridge Insurance Company of Canada*, (11 June 2014), FSCO A12-004886.

21. *Toronto Transit Commission Insurance Company Limited and The Estate of Reuben Marcus, Deceased, by its Executor, Amy Marcus* (19 September 2014), FSCO P14-00005.

22. *Wadhwani v State Farm Mutual Insurance Company*, 2013 ONCA 662, [2013] OJ No 4972.

23. *Willoughby v Dominion of Canada General Insurance Company*, 2014 ONSC 1135, [2014] OJ No 2079.

24. *Zaya and State Farm Mutual Automobile Insurance Company* (28 November 2014), FSCO A12-005753.

25. *Zurich Insurance Company v Chubb Insurance Company*, 2014 ONCA 400, 120 OR (3d) 161, leave to appeal to SCC granted.