Licence Appeal Tribunal File Number: 21-006631/AABS

In the matter of an Application for Dispute Resolution pursuant to subsection 280(2) of the *Insurance Act,* RSO 1990, c I.8., in relation to statutory accident benefits.

Between:

Royal & Sun Alliance Insurance Company of Canada

Applicant

and

Susan Sampson

Respondent

MOTION ORDER

ADJUDICATOR: **Craig Mazerolle**

Motion Order Dated: **May 25, 2022**

BACKGROUND

[1] The respondent, insured person, was injured in an automobile accident on **October 16, 1994**, and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Accidents After December 31, 1993 and Before November 1, 1996* (the "*Schedule*").[1]

[2] The applicant, insurer, filed an application with the Tribunal on May 28, 2021.

NOTICE OF MOTION

[3] The respondent filed a Notice of Motion (submitted November 18, 2021) seeking the following relief:

a. An order dismissing the application; or,

b. In the alternative, an order staying the application until a determination is rendered by the Ontario Superior Court.

[4] The respondent also asked for costs from the applicant.

[5] The applicant opposed the motion.

PARTIES' POSITIONS

[6] The respondent submitted that the applicant failed to issue a proper denial, such that a dispute has not been triggered. Specifically, following an order from the Tribunal finding no valid denial of her attendant care benefit (dated January 19, 2021), the applicant sent the respondent an Explanation of Benefits that did not explain the process for disputing this denial (dated May 28, 2021). Without this information, there is no valid denial, so there is no dispute that establishes the Tribunal's jurisdiction.

[7] Citing *Economical Mutual Insurance Company v. A.S.*[2] ("*A.S.*"), the respondent then contended that the Tribunal has ruled that insurers may only bring applications in limited contexts, namely the repayment of benefits. Of import, the following paragraph from *A.S.* lays out concerns the adjudicator had about such a process:

> In the absence of action taken by A.S. to dispute Economical's determinations by commencing an application at the Tribunal, s. 280 cannot be triggered, regardless of how broad the Tribunal's powers are. Economical cannot pre-empt A.S. by applying to the Tribunal to reinforce its own decisions. It is unclear what

[1] O. Reg. 776/93.
[2] 2020 CanLII 30409 (ON LAT).

Economical even thinks such a process would entail.[3]

[8] Since the applicant is seeking a determination of the respondent's attendant care benefits (not a repayment), the Tribunal does not have jurisdiction to issue what amounts to a declaration. Rather, the Superior Court is the proper forum for the dispute, because only the courts can provide declaratory relief. Finally, the respondent noted that it is improper for two parallel legal proceedings to move forward at the same time (i.e., this application and her Statement of Claim).

[9] The applicant opposed the motion for several reasons. First, the applicant claimed that s. 280 of the *Insurance Act*[4] provides the Tribunal with wide latitude to address any disputes involving accident benefits. Or, as found by the Court of Appeal for Ontario in *Stegenga v. Economical Insurance Company*[5] ("*Stegenga*") and *Dorman v. Economical Mutual Insurance Company*[6] ("*Dorman*"), the courts have no jurisdiction over accident benefits disputes. Therefore, the respondent's submission that the Superior Court has to first rule on her Statement of Claim is without merit, and, by extension, her motion should be dismissed.

[10] The applicant then challenged the respondent's argument that it has not provided a proper denial of the attendant care benefit. While it continues to disagree with the Tribunal's earlier order stating its first denial was invalid (dated January 19, 2021), it has since provided the respondent with a series of letters that clearly deny the benefit. Briefly, once the applicant realized that its first Explanation of Benefits (dated May 28, 2021) did not include instructions about how the respondent could challenge its position about her attendant care benefit, it sent a further letter with this information on November 22, 2021.

[11] In reply, the respondent cited *Smith v. Co-operators General Insurance Co.*[7] ("*Smith*") for the proposition that defects in a denial letter are fatal. She also contended that this present dispute was already addressed as part of the January 2021 motion order. As such, costs are merited.

[12] Following the motion hearing, both parties provided further written submissions. Specifically, they addressed whether a series of letters can be read together to create a valid denial. Of note, the respondent submitted that—while a holistic reading of multiple letters may be appropriate in limited cases—the applicant waited six months between its two letters. This gap renders the second denial letter invalid, especially since it was sent following its application with the Tribunal.

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[3] *Ibid*, at para. 17.
[4] R.S.O. 1990, c. I.8.
[5] 2019 ONCA 615 (CanLII).
[6] 2021 ONCA 314 (CanLII).
[7] 2002 SCC 30 (CanLII).

[13] The parties also discussed *Smith* and my reasoning in *Dino v. Travelers Insurance*[8] ("*Dino*"), with the respondent again claiming that "a contemporaneous letter accompanying a purported denial may remedy a defect", but too much time passed between the two letters. The applicant disagreed that either *Smith* or *Dino* had any relevance to this dispute. Rather, it reasserted its position that the November 22, 2021 letter provided a valid denial.

ANALYSIS

[14] Rule 3.1 of the *Common Rules of Practice and Procedure* (the "LAT Rules") requires the Tribunal to conduct its proceedings in a manner that balances fairness and efficiency, all the while ensuring disputes are decided on the merits of the case.

[15] Sections 280(1) – (4) of the *Insurance Act* provide as follows [citations removed; emphasis added]:

> 280. (1) This section applies with respect to the resolution of disputes in respect of an 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.
>
> (2) ***The insured person or the insurer may apply to the Licence Appeal Tribunal*** to resolve a dispute described in subsection (1).
>
> (3) No person may bring a proceeding in any court with respect to a dispute described in subsection (1), other than an appeal from a decision of the Licence Appeal Tribunal or an application for judicial review.
>
> (4) The dispute shall be resolved in accordance with the *Statutory Accident Benefits Schedule*.

[16] After considering these provisions and the parties' submissions, I am satisfied that the Tribunal has the jurisdiction to hear the applicant's application. As such, the respondent's motion is denied.

Section 280 and Insurer-Led Applications

[17] *Stegenga* provides helpful observations about the expansive nature of s. 280. After commenting on the use of broad, general words like "dispute" and "entitlement", the Court of Appeal reached the following conclusion:

> … Put in terms applicable here, an insured person could properly be said to have a dispute falling within s. 280(1) if a benefit the

[8] 2021 CanLII 37851 (ON LAT).

> insured considers ought to have been paid or provided was not, or if it was paid or provided but only well after the insured considers it should have been because of what the insured considers to have been the insurer's inappropriate handling of the claim. These are matters the legislature has empowered the LAT to decide, and has taken away from the court.[9]

[18] The Court of Appeal later confirmed these findings in *Dorman*:

> As the motion judge noted, no court actions are permitted with respect to either disputes about entitlement to SABs or the amount of the SAB. The LAT has exclusive jurisdiction over such disputes. This was confirmed by this court's decision in [*Stegenga*]. The plaintiff appellants cannot avoid this result with policy arguments that the exclusive jurisdiction of the LAT undermines the purpose of the Act or hinders access to justice. The Act is clear and must be given effect.

[19] These cases are key to my ruling, as they support a broad mandate for the Tribunal by virtue of s. 280. Briefly, if there is a dispute concerning entitlement or quantum of accident benefits, the Tribunal has jurisdiction.

[20] In the present case, it is clear that there is a dispute over the attendant care benefit, as evidenced by the application and the Statement of Claim. Put simply, the parties are at odds over how this benefit has been adjusted, so s. 280 of the *Insurance Act* provides the Tribunal with the sole jurisdiction to address these concerns. The courts have no role at this time.

[21] Despite the applicant's reliance on *A.S.* to challenge this conclusion, I do not find this case is analogous to the present dispute. In addition to the paragraph cited above, the adjudicator's key findings are found in the following paragraphs:

> Economical seeks a determination from the Tribunal regarding A.S.'s "disputed" entitlement to IRBs since its refusal to pay due to a s. 33 suspension of benefits in December 2018… Economical states that it is proper for an insurer to refuse to pay benefits during a period of s. 33 non-compliance and that it is "jarringly notable" that A.S. has not commenced an application for the "disputed" IRBs. Economical argues that it does not have to be "held hostage in perpetuity" by an insured and that it can, and has, applied to the Tribunal to resolve the dispute and to seek an Order that IRBs are not payable.

[9] *Stegenga*, at para. 53.

> I disagree. To begin, and again, A.S. has not yet disputed Economical's determination to suspend his IRB, despite its contention otherwise. In fact, since there is no denial, the two-year limitation period has not elapsed and does not elapse until December 2020. To allow an insurer to apply to the Tribunal for an endorsement of its decision or an enforcement of s. 33 would render the two-year limitation period meaningless. A.S. can still comply with the s. 33 requests or dispute the determination, just as Economical can still terminate the IRB and trigger the limitation period… Accordingly, it is difficult to accept how Economical is being held hostage when the decision to suspend and not terminate IRBs was its own and no payments are being made.
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> […] Indeed, the only recourse for an insurer to apply to the Tribunal as the applicant is when it is seeking repayment of specified benefits through error, fraud or misrepresentation. The "Application by an Insurance Company" Form specifically asks whether the insurer is claiming a repayment of benefits, which applies to all of IRB, non-earner, caregiver, attendant care and medical and rehabilitation benefits.[10]

[22] There is a significant difference between this case and the current dispute. As noted above, both the insured person and the insurer to this present matter have filed claims in different legal forums. There is clearly a dispute between the parties. This disagreement was not present in *A.S.* (aside from the request for a repayment of the income replacement benefit), so the adjudicator expressed concerns about an insurer using the Tribunal to confirm a denial that had not been contested by the insured person. This concern does not apply.

[23] I would also note that the adjudicator's concerns about what a process would look like if an insurer were able to start disputes is premature. The parties have not attended a case conference, so they have not had the chance to discuss what the hearing process might look like. It would also run counter to the expansive definition of s. 280 from *Stegenga* and *Dorman* if this wide jurisdiction could be overridden due to difficulties in achieving an effective hearing process.

[24] Finally, though I recognize the "Application by an Insurance Company" form asks whether an insurer is claiming a repayment, there is the option to check "No". In fact, the respondent checked off "No" on the present application. Though Tribunal forms cannot be used to establish a definitive understanding of the Legislature's intention, the option to select "No" provides evidence for the

[10] *A.S.*, at paras. 19 – 20, 22.

position that this Tribunal can address insurer-led applications that do not involve repayment.

Applicant's Denial Letters

[25] I then conclude that a proper denial of the attendant care benefit has been issued by the applicant.

[26] The previous motion order from the Tribunal (dated January 19, 2021) was mainly premised on the finding that: "There must be a clear denial to engage or trigger the Tribunal's jurisdiction." Since the adjudicator did not find there was a clear denial in the previous Explanation of Benefits (dated November 11, 2019), he concluded there was no jurisdiction via s. 280 of the *Insurance Act*.

[27] In response to this motion order, two letters were sent on May 28 and November 22, 2021. Starting with a statement that the applicant did not agree with the Tribunal's motion order, it laid out the purpose of the letter as follows:

> …this letter is intended to set out[11] [the applicant's] position with respect to [the respondent's] entitlement to retroactive and ongoing attendant care benefits, indexation, and interest, following receipt of the Form-1 and accompanying Assessment of Attendant Care Needs Report, prepared by Claudia Maurice, Occupational Therapist, dated December 27, 2018, submitted under cover letter of February 5, 2019, and followed by Ms. Maurice's addendum reports dated May 25, 2020, July 29, 2020, and January 30, 2021.
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> Since October 9, 1996, [the applicant] has paid the cost of [the respondent's] institutional care plus invoices as submitted for care required by [the respondent] over and above that which has been provided within the retirement or long term care facilities at which she has lived. It is [the applicant's] belief that its payments have been in accordance with its obligations under the *Schedule* where an insured person is receiving both the services of an aide or attendant and the cost of long term care.

[28] In addition to providing a summary of communication between the parties after Ms. Maurice's first report (i.e., between February 2019 to May 2021 in the May 2021 letter, and up to September 2021 in the second letter), the letters explained the applicant's decision concerning entitlement to an attendant care benefit. Since the November 2021 letter cited and summarized the reasons from the May 2021 letter, I will cite the original reasons from the May 2021 for ease of

[11] A difference between the two letters from this quotation is that the May 2021 letter here used the phrase "set out", while the November 2021 here used the word "reassert".

reference:

> It is [the applicant's] position that this is not a situation in which [the respondent] can now rely upon a "retroactive Form 1" to claim past attendant care benefits or interest, where attendant care claims have been advanced, paid and assessed for a period of more than two decades.
>
> As stated previously, regarding any potential retroactive attendant care amounts owed, and [the respondent's] ongoing entitlement to attendant care services. [The applicant] asserts that [the respondent] is entitled only to reimbursement for the cost of services provided in the long term care facility/facilities in which resides and/or resided, plus an amount for additional services required and received by her on a monthly basis. It is [the applicant's] position that it has paid all incurred expenses for attendant care up to and including the present and therefore the amount owing in accordance with Ms. Maurice's retroactive Form 1 assessments (plus interest) is nil, as previously set out in the Explanation of Benefits dated February 25, 2019.
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> To the extent that greater clarity is required, please accept this as notice that [the applicant] denies any and all claims for past attendant care and interest beyond amounts previously paid.

[29] As noted above, the May 28, 2021 letter did not include information instructing the respondent on her options to challenge this determination. This information was contained in the November 22, 2021 letter, along with the following summary of the May 2021 letter:

> [The applicant] advised of its position that this claim is not a situation in which [the respondent] can now rely upon a "retroactive Form 1" to claim past attendant care benefits or interest, where attendant care claims have been advanced, paid and assessed for a period of more than two decades.

I am satisfied that the summary provided in this second letter went on to provide the same reasons as the May 2021 letter.

[30] On a plain reading of the paragraphs produced above, I am satisfied that the letters contained sufficient information to establish the applicant's decision concerning the respondent's attendant care benefit—an unequivocal denial that meets the standard of *Smith*. I am also satisfied that the November 22, 2021 contained information about the respondent's ability to contest the determination. Put simply, the applicant provided the following information: what it was and was

not willing to pay for; the reasons for this decision; and instructions on how to challenge this decision.

[31] As summarized above, the respondent took issue with the position that a series of letters can be read together to form a proper denial (or, at least, when this correspondence is sent over an extended period). Even if I accepted this position, I find that this determination would make little difference. I am satisfied that the November 22, 2021 letter remedied any deficiencies from the May 28, 2021 letter. Put another way, regardless of whether I am willing to read the letters together or not, there was a valid denial as of November 22, 2021.

[32] In turn, I do not place much weight on the respondent's argument about the timing of the second letter. It is true that it was released after both the application and this Notice of Motion were filed. However, similar to my finding concerning the Court of Appeal's broad interpretation of s. 280, it would be improper for the Tribunal to strike an application after a party has taken steps to remedy an alleged procedural deficiency. Instead, it is more appropriate to allow parties to remedy procedural deficiencies in ways where the dispute is able to proceed in a manner that meets the mandate of Rule 3.1 of the LAT Rules—all the while respecting this broad grant of jurisdiction.

[33] A similar course of action can be taken when an insured person has not attended an insurer's examination scheduled under s. 44(1) of the *Schedule*. While s. 55(1) allows the Tribunal to strike an application for this breach, the Tribunal may also grant a stay of proceedings to provide the parties with time to address the breach. Different considerations must be made for insurer-led applications, namely, the consumer protection principle underpinning the *Schedule* leans in favour of allowances under s. 55. However, the mandate for efficient, fair, and merits-based adjudication under Rule 3.1 supports this interpretation, regardless of the party who initiated the application.

Stay of Proceedings

[34] As an alternative form of relief, the respondent asked to stay these proceedings until the Superior Court ruled on her Statement of Claim. Since I am satisfied that the Tribunal has the jurisdiction to hear the application, I see no reason why this proceeding should be stayed pending the Superior Court's determination.

[35] The respondent expressed concerns about the inefficiencies that would arise with two, parallel legal proceedings. I do not share this concern. Any aspect of the respondent's Statement of Claim that is not captured under s. 280 of the *Insurance Act* will proceed with the Superior Court (similar to the ruling in *Dorman*). For instance, if the courts choose to hear the respondent's claim of "fraudulent concealment", this submission can proceed in that forum. If not, the

Tribunal could incorporate these arguments into the hearing process. As such, any ruling made by the courts concerning the jurisdiction of the Tribunal can be effectively and efficiently accommodated during the lifespan of this application.

Respondent's Costs Request

[36] Turning to the respondent's request for costs, I do not find the applicant's behaviour merits this exceptional relief.

[37] Rule 19.1 of the LAT Rules allows the Tribunal to order costs where a party has acted in a manner that is unreasonable, frivolous, vexatious, or bad faith. I am not satisfied that the applicant acted in a manner that would require costs. Rather, the applicant took steps to file an application in a manner it believed was in line with an order from the Tribunal. Nothing in these actions evidences behaviour that reaches the high and exceptional threshold of Rule 19.1.

ORDER

[38] The respondent's motion is denied.

[39] No costs will be ordered as part of this motion hearing.

Released: May 25, 2022

Craig Mazerolle
Adjudicator