THE REAL STORY FROM THE DAILY PLANET'S STAR REPORTER

Special Awards and the LAT

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As you know, as of April 1, 2016, the statute dealing with what was formerly known as a "Special Award" under former Section 282(10) of the *Insurance Act,* R.S.O. 1990 c. I.8, was replaced by an award pursuant to Section 10 of the *Automobile Insurance Act*, R.R.O. 1990, Reg. 664, which states:

> DISPUTE RESOLUTION (SECTION 280 OF THE ACT)
>
> 10. If the Licence Appeal Tribunal finds that an insurer has unreasonably withheld or delayed payments, the Licence Appeal Tribunal, in addition to awarding the benefits

> and interest to which an insured person is entitled under the Statutory Accident Benefits Schedule, may award a lump sum of up to 50 per cent of the amount to which the person was entitled at the time of the award together with interest on all amounts then owing to the insured (including unpaid interest) at the rate of 2 per cent per month, compounded monthly, from the time the benefits first became payable under the Schedule.
> *[emphasis added]*

The change to the new statute grants discretion to the Licence Appeal Tribunal (the "Tribunal"), and states that the Tribunal "may award a lump sum" of up to 50% under the section, whereas an award under the former Section 282(10) was mandatory if benefits were found to be unreasonably withhold or delayed.

LAT Cases – No Lump Sum Award Ordered

As of the time of this paper, there are a handful of cases published to CanLII where the LAT has considered granting an award under Section of O. Reg. 664, but has found that such an award was not warranted in the circumstances.

***J.T. v. Intact Insurance Company* (2016 CanLII 78333)**

In *J.T.*, the parties had settled the one issue in dispute at the start of the Case Conference. However, the Applicant wanted to recover his costs for preparing his Application and alleged that Intact had acted unreasonably. As the parties were not able to come to an agreement on the issue of costs, they proceeded to a preliminary issue hearing for the Applicant's request, wherein the Applicant also sought an award pursuant to Section 10 of O. Reg. 664. The Applicant took the position that the insurer unreasonably withheld and delayed payment of a benefit because it did not pay for a disbursement fee of $39.83 which, according to the Applicant, if the insurer had paid, it would have had the documents necessary to adjust the file and approve the treatment plan in dispute at an earlier date. Adjudicator Treksler and Adjudicator Sewrattan acting as a Panel noted that under Section 33 of the SABS, the Applicant was required to provide any information reasonably required to

assist the insurer in determining the Applicant's entitlement to a benefit. The Panel noted that in this case, the Applicant had advised the insurer that he would provide documentation to it, but never did so, and instead chose to file an Application with the Tribunal. In this case, the Panel found that the insurer did not withhold or delay payment of a benefit, as it was waiting for updated medical records which were in the Applicant's possession, and that once these records were received, the Treatment Plan was approved. The Panel noted that the Applicant had an obligation to send these documents without expecting for the insurer to pay for the disbursement fee up front, and therefore found that the insurer acted reasonably and the Applicant was not entitled to an award pursuant to Section 10 of O. Reg. 664.

***R.M. v. Optimum Insurance Company* (2016 CanLII 96165)**

In *R.M.*, the issue in dispute was the alleged interest owed on income replacement benefits to the Applicant. At the time of the accident, the Applicant was both employed and self-employed at the time of the accident. The Applicant disputed the quantum over a period of approximately six years on the basis of the insurer's initial miscalculation of the IRB amount. At the Hearing, there was a question as to whether the Applicant's self-employment income was ever reported. However, the Applicant took the position that the income information was made available to the insurer early on, that the information relating to self-employment income was available to the insurer's accountant at the time her initial income replacement benefit calculation was conducted, and therefore, interest should be paid as the calculation could and should have been done on the basis of the Applicant's earnings for the 52 weeks prior to the accident. As a result of the differential resulting from the miscalculation, interest was ordered on the overdue amount. In considering whether an award under Section 10 of O. Reg. 664 should be granted, Adjudicator Bickley concluded that the insurer had not unreasonably withheld or delayed payments. Despite the fact that the miscalculation was made in August 2008, the Applicant did not object to that calculation at any time up until March 2014, during which period both the Applicant and insurer proceeded as if the original IRB calculation was correct. While finding that the Applicant's 2008 self-employment income was not unreported income within

the meaning of Section 64.1 of the SABS, Adjudicator Bickley found that it was not unreasonable in 2014 for the insurer to seek to assure itself that a 2008 self-employment income had been reported, and that once it was in possession of the 2008 Notice of Assessment, the insurer moved in a reasonable time to re-calculate and pay the amounts owing. Therefore, in the circumstances, Adjudicator Bickley declined to grant an order for an award pursuant to Section 10 of O. Reg. 664.

***J.W. v. The Cooperators General Insurance Company* (2016 CanLII 96170),**

In *J.W.*, Vice-Chair Richards declined to order an award under Section 10 of O. Reg. 664 as he determined that the Applicant failed to comply with the SABS for failing to attend the insurer's examination, and therefore found that the insurer's consequent withholding of benefits was reasonable.

***E.K. v. Unifund Assurance Company* (2017 CanLII 69237)**

In *E.K.*, the parties were able to settle the one issue in dispute of a medical benefit Treatment Plan for chiropractic services at the resumption of case conference, but did not resolve the issue of costs. In his analysis, Adjudicator Makos, noted that in the application filed with the Tribunal, there was no mention of a claim for an award under Section 10 of O. Reg. 664, however, this request was made as part of the Applicant's submissions after the disputed benefit was paid for by the insurer. Adjudicator Makos was persuaded by the FSCO decision of *Rocca v. AXA* (FSCO A97-000903), which found that withholding or delaying of benefits until shortly before the hearing could attract a special award if the insurer's actions were unreasonable. Adjudicator Makos was also persuaded by the FSCO appeal decision of *Jensen v. GAN Canada* (FSCO P96-00079), wherein it was held that the insurer's agreeing to pay disputed benefits did not necessarily dispose of the question of a special award. Adjudicator Makos therefore found that the Tribunal had jurisdiction to consider the request under Section 10 of O. Reg. 664 despite the fact that the Treatment Plan in dispute had been resolved.

Despite finding that he could order a lump sum award in the circumstances, Adjudicator Makos declined to order an award pursuant to Section 10 of O. Reg. 664 as he was unable to find that the insurer has unreasonably withheld or delayed payment of the benefit. In his analysis, Adjudicator Makos rejected the Applicant's position that the insurer improperly denied the Treatment Plan on the basis that it did not have sufficient medical evidence, noting that neither of the Applicant's assessor's reports had suggested the Applicant required further treatment, and rejected the Applicant's argument that there was no medical explanation provided for the denial in compliance with Section 38(8). Further, Adjudicator Makos noted that the onus was not on the insurer to seek out information to justify requests for benefits from an applicant, and while the insurer did not request the Applicant to provide updated medical records from a specific health practitioner, it did make a generalized request for medical clinical notes and records indicating the applicant required further treatment as a result of the accident. Adjudicator Makos further rejected the Applicant's assertion that the insurer failed to schedule an insurer's examination after receiving the completed Disability Certificate and Treatment Plan which were denied, noting that the insurer was not obligated to conduct an examination under section 44 of the SABS based on references to treatment or the need for treatment posed in a Disability Certificate. Adjudicator Makos noted that in this situation, instead of putting the Applicant through the inconvenience of an insurer examination for the disputed medical benefits, it chose to request updated medical information to support the claim for further benefits. Therefore, Adjudicator Makos found no evidence that the insurer unreasonably withheld or delayed payment of the requested benefits, and noted that at the outset of the denial, the insurer requested the Applicant to provide updated medical information to support her need for further care, and that once the information was provided the insurer responded promptly and reversed its denial and paid the benefits. No award pursuant to Section 10 of O. Reg. 664 was granted.

LAT Cases – Lump Sum Awards at the LAT

As of the time of this paper, there were only two published decisions of the Tribunal on CanLII where an adjudicator had awarded a lump sum under Section 10 of O. Reg. 664.

***F.P. v. Aviva Insurance Company* (2017 CanLII 62160)**

In the decision of *F.P. v. Aviva Insurance Company*, the issue in dispute was whether the Applicant was entitled to a number of Treatment Plans, two of which were for physiotherapy services denied in September 2014 and November 2015, and two cost of examinations denied in March 2016 for an orthopaedic assessment and a psychiatric assessment, respectively. The Applicant also sought an award under Section 10 of O. Reg. 664, and interest. In her analysis, Adjudicator Treksler noted that with respect to the first physiotherapy Treatment Plan, both parties agreed that the Applicant suffered from chronic pain, however the insurer had denied the Treatment Plan on the basis that the Applicant would not recover from his injuries with the proposed treatment. In finding that the Treatment Plan was reasonable and necessary, Adjudicator Treksler noted that the assessors indicated the Applicant's pain would persist and he would not be expected to make a full recovery, but found that the goals of the Treatment Plan to reduce or manage the Applicant's pain were valid, and accepted the Applicant's evidence that the physiotherapy helped to manage his pain and get him through the week. Adjudicator Treksler further rejected the insurer's raising a new issue that the Applicant failed to attend an IE for the physiotherapy Treatment Plan, noting that this defence had not been raised at the Case Conference, and that given that the Applicant had attended an IE in 2014 regarding his entitlement to another physiotherapy treatment plan, that it was not reasonable and necessary for the insurer to require the Applicant to undergo another one year later. Both physiotherapy Treatment Plans were to be found reasonable and necessary. Adjudicator Treksler further rejected the insurer's argument that orthopaedic assessment and psychiatric assessment, in particular, were not reasonable and necessary on the basis that the Applicant had failed to attend an approved chronic pain assessment as irrelevant. Adjudicator Treksler also rejected the insurer's

argument that the approval of the psychiatric assessment should be dismissed on the basis that the Treatment Plan was signed by a medical doctor, not a psychiatrist, as Section 38(2) of the SABS only required that a Treatment Plan be signed by a member of a health profession or by a social worker. Adjudicator Treksler agreed with the Applicant's position that as the prior assessments were conducted in 2012, the Treatment Plans were reasonable and necessary in order to get an updated status on the Applicant's condition, and what type of treatments would best facilitate his rehabilitation.

In granting an award under Section 10 of O. Reg. 664, Adjudicator Treksler noted that the insurer did not dispute that the Applicant had chronic pain syndrome, and noted regarding the treatment goals, "I am of the view that the goal for treatment for this Applicant should be pain relief and reduction given his chronic pain diagnosis. As such, I do not agree with the Respondent's rationale that given the Applicant is not able to able to recover from his injuries that further physiotherapy treatment is not reasonable and necessary." Adjudicator Treksler also noted that the prior assessments on file were dated, and that given the persistent need due to the Applicant's chronic pain, found it reasonable that the Applicant had requested to undergo new assessments in order to determine if the assessors could recommend other treatments at that stage of his chronic pain. Having found that all the Treatment Plans in dispute were reasonable and necessary, Adjudicator Treksler concluded that the insurer had delayed payment for one to three years, which had affected the Applicant's ability to effectively manage his chronic condition, and that according to the Applicant's evidence he had to incur the costs of a physiotherapy service, which impacted him financially. Adjudicator Treksler therefore concluded that an award under Section 10 of O. Reg. 664 was warranted, and awarded 50% of the disputed amount plus interest.

***V.H. v. Belair Direct Insurance* (2017 CanLII 70688)**

In the recently released Amended Decision of *V.H. v. Belair Direct Insurance*, in dispute were a number of issues including CAT designation, and entitlement to income replacement benefits, medical benefits for a mattress and adjustable bed, and attendant care benefits. The hearing was

held in person from April 4 to 6, 2017. The day before the hearing on April 3, 2017 at around 5:00 p.m., the insurer accepted the Applicant's catastrophic designation, and agreed to pay for income replacement benefits including interest, and the medical benefits for a mattress. The issue of attendant care benefits was not able to be resolved as the insurer's position was that the provider was not working as a PSW at the time of the accident, and therefore per the SABS was required to prove an economic loss which the insurer claimed the Applicant had failed to do. Adjudicator Treksler and Adjudicator Hines, sitting as a Panel, accepted the Applicant was entitled to attendant care benefits. However, the Panel for the Tribunal found at the Applicant was not entitled to an award under Section 10 of O. Reg. 664 for the delay in payment of the attendant care benefits, medical benefits, or in relation to the decision of CAT designation. In its analysis, the Panel noted, "we find that it is not necessary to determine whether the Respondent had unreasonably delayed the Applicant's CAT designation as a designation is not an award for payment of benefits, but rather the ability to access those benefits. Therefore, even if we had found that the Respondent had delayed the Applicant's CAT designation, we would not be able to grant an award because the Respondent had not unreasonably withheld or delayed payments." With respect to the attendant care benefits, the Panel found that the insurer had responded promptly to the application for attendant care benefits and made clear its position, and that it was not unreasonable for it to have made inquiries as to the attendant care provider's economic information under Section 3(7) of the SABS. Further, while there were some errors in the insurer's letters, which the Panel acknowledged could have caused some confusion and distress for the Applicant, it did not create an unreasonable delay in the payment of attendant care benefits and therefore no award was ordered. Regarding the medical benefit for a mattress and adjustable bed, the Panel found that the insurer responded in a reasonable time regarding the denial of the claim and arranging an assessment, and there was no evidence before the Panel that the insurer had unreasonably withheld or delayed the payment. However, the Panel did grant an award pursuant to section 10 of O. Reg. 664 with respect to the denial of income replacement benefits, as it found the insurer has unreasonably withheld and delayed payment of this benefit in the circumstances. The Panel recognized that the Applicant operated her own company,

and that the calculation of her income replacement benefit was complex, however, it accepted the evidence of the Applicant's accounting firm, Collins Barrow, that the Applicant had provided sufficient documentation to calculate her income replacement benefits. The Panel accepted Collins Barrows' opinion that the insurer's accounting firm, H&A, requested information that was beyond what was reasonably necessary for its purpose, and was excessive. The Panel found that the delay in payment of income replacement benefits of approximately ten months had an emotional and financial impact on the Applicant, who had accrued debts due to the non-payment of benefits. As a result, the Panel found that an award under O. Reg. 664 was warranted, but did note that the insurer did agree to pay the weekly amount of income replacement benefits including interest on the eve of the hearing as per the Applicant's initial claim. This was found to be a mitigating factor and therefore, instead of an award of up to 50%, the Panel chose to award 30% of the amount owed to the applicant at the time of the hearing plus interest.

The Future of Awards Pursuant to Section 10 of O. Reg. 664?

While there are currently less than a dozen published Tribunal cases where the merits of an award pursuant to Section 10 of O. Reg. 664 have actually been considered, the recent cases have shown a willingness by Adjudicators to consider a lump sum award in a wide range of situations.

From the cases referenced in this paper, even when a lump sum award pursuant to Section 10 of O. Reg. 664 is ultimately not awarded, we note that it appears that the Tribunal is willing to broadly apply consideration as to whether there was an unreasonable withholding or delayed payment of benefits. It would appear from the few cases before us that even in situations where an insurer may settle some of the issues in dispute at a Case Conference or before a Hearing, if there remain issues in dispute, such as costs or entitlement to other accident benefits, the Tribunal appears to accept that it may consider a lump sum award even as it would relate to any issues resolved before the Hearing. However, the cases show that payment of the benefit in dispute plus any applicable interest in advance of a Hearing is viewed as a mitigating factor which will be considered by the

Tribunal in both granting an award and the quantum. Other mitigating factors appear to the compliance with the SABS by the insurers, timing of the denials where it can be shown that an insurer communicated prompt and clear denials to applicants, and that there was minimal delay in paying any benefits once it was determined a benefit should be paid. On the other hand, any hardship to the Applicant as a result of the withholding or delaying benefits will likely be seen as a factor influencing an Adjudicator's decision to grant an award.

To date, what we have yet to see with the case law is whether the Tribunal will also be willing to consider an award pursuant to Section 10 of O. Reg. 664 in situations where all issues have been resolved prior to a Hearing and the only live issue going forward is a lump sum award. However, given the analysis in *E.K. v. Unifund Assurance Company*, and *V.H. v. Belair Direct Insurance*, as above, we suspect that the Tribunal may be persuaded by FSCO precedents to consider an award in those circumstances.

The few Tribunal decisions available demonstrate that the analysis for granting an award pursuant to Section 10 of O. Reg. 664 remains largely a factual one, and will vary from case to case. However, with the Tribunal's willingness to consider a lump sum award in cases where some partial agreement has been reached between the parties, we anticipate that Applicant's counsel will increasingly claim an award pursuant to Section 10 of O. Reg. 664 in their cases, and especially in cases where denials may be at or near the 2 year limitation period where a claim could be advanced that significant time had passed and alleging hardship to the applicants. We believe insurers should be prepared to face increased allegations of unreasonable withholding or delay of payment, and recognize that payment or settlement of the issues alone may not be the end of the dispute. Given that the award of costs has been all but removed at the Tribunal, in an effort to recoup some expenses, we expect the cases involving an award under Section of O. Reg. 664 to only become more pronounced with time.