COURT OF APPEAL FOR ONTARIO

CITATION: Henry v. Gore Mutual Insurance Company, 2013 ONCA 480
DATE: 20130716
DOCKET: C55845

Simmons, Hoy and Strathy JJ.A.

BETWEEN

Tyrone Henry

Applicant (Respondent)

and

Gore Mutual Insurance Company

Respondent (Appellant)

Philippa G. Samworth, for the appellant

Joseph Y. Obagi, for the respondent

Heard: May 16, 2013

On appeal from the judgment of Justice Timothy D. Ray of the Superior Court of Justice dated June 27, 2012, with reasons reported at 2012 ONSC 3687.

Hoy J.A.:

I. OVERVIEW

[1] The respondent, Tyrone Henry, was left a paraplegic after a motor vehicle accident on September 28, 2010. His mother took an unpaid leave of absence from work to provide the full-time care he required.

[2] In 1990, limits were introduced on tort compensation for victims of automobile accidents and insurers were required to provide various benefits prescribed by regulation, including paying for the reasonable and necessary expenses incurred by or on behalf of an insured for attendant care, subject to various limitations, regardless of whether the insured was at fault.

[3] The issue on this appeal is whether, under the regulation in effect at the time of the respondent's accident – the *Statutory Accident Benefits Schedule – Effective September 1, 2010*, Ont. Reg. 34/10 ("SABS-2010") – the appellant insurer, Gore Mutual Insurance Company, is required to pay attendant care benefits for the entire 24 hours per day that the respondent required, and the mother provided, care, or only for the care provided during the 40 hours per week of paid employment foregone by the mother. The insurer took the position that because the mother worked an eight hour day, the amount payable for attendant care benefits would be pro-rated, based on an eight hour day.

[4] The application judge concluded that the insurer's obligation to pay for attendant care benefits was not restricted to care provided during the 40 hours per week of paid work foregone by the mother. I agree, and, for the reasons that follow, would dismiss this appeal.

II. SABS 2010 - THE RELEVANT PROVISIONS

[5] This appeal turns of the interpretation of the term “incurred” defined in s. 3 (7)(e) of SABS-2010:

> 3(7) For the purposes of this Regulation,
>
> …
>
> (e) …, an expense in respect of goods and services referred to in this Regulation is *not incurred by an insured person unless,*
>
> (i) the insured person has received the goods or services to which the expense relates,
>
> (ii) the insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and
>
> (iii) the person who provided the goods or services,
>
> (A) did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or
>
> (B) sustained an economic loss as a result of providing the goods or services to the insured person;
>
> [Emphasis added.]

The appellant concedes that the requirements of 3(7)(e)(i) and (ii) are met, and that the mother sustained an economic loss as a result of providing attendant care services to the respondent. The issue is whether an expense was incurred by the respondent with respect to the attendant care services provided by his mother outside of her normal hours of work.

[6] “Economic loss” is not defined in SABS-2010.

[7] The term “incurred” is used in s. 19 of SABS-2010, which governs payment of attendant care benefits:

> 19(1) Attendant Care benefits shall pay for all reasonable and necessary expenses,
>
> > (a) that are *incurred* by or on behalf of the insured person as a result of the accident for services provided by an aide or attendant…
>
> 19(2) Subject to subsection (3), the amount of a monthly attendant care benefit is determined in accordance with the version of the document entitled “Assessment of Attendant Care Needs” that is required to be submitted under section 42 and is calculated by,
>
> > (a) multiplying the total number of hours per month of each type of attendant care listed in the document that the insured person required by an hourly rate that does not exceed the maximum hourly rate, as established under the Guidelines, that is payable in respect of that type of care; and
> >
> > (b) adding the amounts determined under clause (a), if more than one type of attendant care is required.
> >
> > [Emphasis added.]

[8] Subsection 3(7)(c) defines an aide or attendant to include “a family member or friend who acts as the person’s aide or attendant, even if the family member or friend does not possess any special qualifications”.

[9] Subsection 19(3) sets out maximum amounts payable for attendant care. Unless increased by optional benefits, the amount of the attendant care benefit for someone such as the respondent who sustained a catastrophic impairment as

a result of the accident shall not exceed $6,000 per month and $1,000,000 for any one accident.

[10] The document entitled “Assessment of Attendant Care Needs” that is required to be submitted under s. 42 of SABS-2010, and referred to in s. 19(2), is known as “Form 1”. Section 42 provides that it must be prepared and submitted to the insurer by an occupational therapist or a nurse. It sets out the weekly attendant care needs of the insured, at various levels of care, and applies a statutory rate to each level, to calculate the total monthly care benefit payable. Subsection 42(3) provides that the insurer may, by notice to the insured, challenge a Form 1 within 10 days after receiving it. The insurer must specify “the expenses described in the assessment of attendant care needs the insurer agrees to pay, the expenses the insurer refuses to pay and the medical and any other reasons for the insurer’s decision.” Under ss. 42(4) and 44(1), it may require the insured to undergo an examination by persons chosen by the insurer who are regulated health professionals or who have expertise in vocational rehabilitation; however, s. 42(6) requires that the insurer “begin payment of attendant care benefits within 10 business days after receiving the assessment of attendant care needs and, pending receipt by the insurer of the report of any examination under section 44, shall calculate the amount of the benefits based on the assessment of attendant care needs.”

[11] Finally, subsection 33(1) requires an insured, within 10 business days after receiving a request from the insurer to provide the insurer with certain information, including, "[a]ny information reasonably required to assist the insurer in determining the applicant's entitlement to a benefit." And subsection 33(6) provides that an insurer is not liable to pay a benefit in respect of any period during which the insured fails to comply with subsection 33(1).

III. THE APPLICATION JUDGE'S DECISION

[12] The application judge commented that the intent of SABS-2010 was "to prevent a member of an insured's family who was not ordinarily an income earner or working outside the home, from profiting from an attendant care benefit, when they would likely be at home anyway – and would have looked after the injured person without compensation."

[13] He noted that "economic loss" was not defined in SABS-2010. He reasoned:

> If the amount as opposed to the fact of economic loss were intended to be relevant, then one would expect the regulations to be of assistance in calculating the amount, since economic loss has been defined in very broad terms in claims for compensation in tort law cases, and has been the subject of a great deal of jurisprudence because of the difficulty in quantification. This omission implies that no such calculation is relevant beyond a finding that the person has "*sustained an economic loss*" – or not. It is a threshold finding for "incurred expense", but is not intended as a means of calculating the quantum of the incurred expense. I

> accept that the amended provisions now eliminate claims by non professional service providers who have not sustained an economic loss.

[14] On a "plain reading" of s. 19(1), if a family member stays home from work and loses income in order to provide all reasonable and necessary attendant care to the insured, and the insured is obligated to pay, promises to pay or does pay the family member, then the definition in s. 19(1) has been met. The insurer must pay all reasonable and necessary attendant care expenses to the insured as described in the Form 1.

IV. THE APPELLANT'S SUBMISSIONS

[15] The appellant argues that the application judge made two errors in interpreting SABS-2010.

[16] First, his interpretation does not give effect to the word "the", which precedes "goods or services" in s. 3(7)(e)(iii)(B). That word co-relates the economic loss to the particular services provided to the insured person. In this case, the respondent's mother only sustained an economic loss as a result of providing the attendant care services she provided during the hours that she would otherwise be working, and the appellant is therefore only required to pay for attendant care in respect of those hours.

[17] Moreover, the legislative history indicates that SABS-2010 was intended to limit compensation payable to family members. If the insurer is required to pay

the insured for all attendant care provided by a family member during the period of economic loss, SABS-2010 would not achieve that objective.

[18] Second, the application judge erred in finding that the insurer must pay all of the expenses described in the Form 1. Payment in accordance with Form 1 is not automatic. The Form 1 identifies attendant care needs, but does not constitute evidence that expenses have been incurred. The insurer is entitled to request additional information from the insured to satisfy itself that an expense has been incurred: see *McKnight v. Guarantee Co. of North America*, FSCO A02-000299, 2003 CarswellOnt 5408, at paras. 11-13; *Stargatt v. Zurich Insurance Co.*, FSCO P01-00045, 2003 CarswellOnt 6358, at para. 32; *Fernandes (Attorney of) v. Certas Direct Insurance Co.*, FSCO P06-00030, 2008 CarswellOnt 988, at paras. 45 and 47. The application judge's interpretation would hamper insurers' ability to combat fraud.

[19] I address these two issues in turn.

V. ANALYSIS OF ISSUE ONE

(1) Guiding approach and conclusion

[20] In my approach to the first issue before me, I am guided by this court's decision in *Monks v. ING Insurance Co. of Canada* 2008 ONCA 269, 90 O.R. (3d) 689.

[21] In *Monks*, this court considered the interpretation of the word “incurred” in the *Statutory Accidents Benefits Schedule–Accidents on or after November 1, 1996*, O. Reg. 403/96 (“SABS-1996”). The word “incurred” was not defined in SABS-1996. At para. 51, the court noted that SABS-1996 was incorporated in every standard insurance policy by virtue of s. 268(1) of the *Insurance Act*, R.S.O. 1990, c. I.8 (the “Act”). The court explained that, as such, the principles applicable to the construction of insurance coverage provisions were applicable to it: insurance coverage provisions are to be interpreted broadly, while coverage exclusions or restrictions are to be construed narrowly in favour of the insured. To the extent that the word “incurred” restricts coverage available to the insured, it must be assigned a narrow meaning.

[22] Applying *Monks*, I agree with the application judge that, under SABS-2010, economic loss serves as a threshold for entitlement to (and not as a measure or factor in quantifying the amount of) reasonable and necessary attendant care benefits to be paid by an insurer. I conclude this based on the language used, the scheme and logic of SABS-2010, and the fact that the legislature could have, but did not, include a provision in SABS-2010 for calculating the amount payable where a family care-giver sustains an economic loss as a result of providing required care to an insured. Moreover, this interpretation is not inconsistent with the evolution of the regulations governing payment for attendant care provided by family members or the five-year report on automobile insurance in Ontario

released by the Financial Services Commission of Ontario (“FSCO”) shortly before SABS-2010 came into force.

(2) The language used

[23] I do not read the word “the” in s. 3(7)(e)(iii)(B) as necessarily limiting an insured’s entitlement to attendant care benefits to those provided during the hours that the family member would otherwise be at work. In my view, applying *Monks*, “the goods or services” in s. 3(7)(e)(iii)(B) should be broadly construed to refer to “the goods or services referred to in [SABS-2010]” referenced in the opening words of s.3(7)(e). SABS-2010 refers to a number of kinds of goods and services, including, in s. 19(1)(a), the services provided by an aide or attendant. Accordingly, I read s. 3(7)(e)(ii)(B) as referring to “an economic loss as a result of providing services as an aide or attendant”.

(3) The scheme and logic of SABS-2010

[24] This interpretation is also consistent with the scheme and logic of SABS-2010. Subsection 19(2) provides that, subject to the maximums set out in subsection 19(3), “the *amount* of a monthly care benefit” is *determined* in accordance with the Form 1 required to be submitted under s. 42, and is calculated based on the number of hours of each type of attendant care *that the insured person requires*. As the respondent argues, s. 19(2) makes clear the underlying premise that, once entitlement is determined, the amount of the

benefit is based on the insured's need for care. That amount is, of course, subject to the maximums in s. 19(3), and the insurer has the right to challenge a Form 1 (pursuant to s. 42) and to request certain information to assist it in determining the insured's entitlement (pursuant to s. 33).[1]

(4) What SABS-2010 does not say

[25] As the application judge indicates, if the amount of the monthly care benefit were to be calculated based upon the number of hours the family care-giver was unable to work because she was providing care, or the quantum of the economic loss sustained by the care-giver, SABS-2010 could have so indicated. SABS-2010 is comprehensive legislation. In ss. 4, 7, 8, 9 and 30, it includes detailed formulas for the calculation of income replacement benefits, the adjustment of those benefits after age 65 and their indexation.

[1]The SABS-2010 also provides the insurer with other safeguards. For example, pursuant to s. 46.2(1), an insurer may also request a person who submits an invoice for payment for attendant care to provide any information required to assist the insurer, acting reasonably, to determine its liability for payment. And pursuant to s. 53, an insurer may terminate payment of benefits if the insured person has wilfully misrepresented material facts with respect to the application for the benefit and the insured has been provided with notice setting out the reasons for the termination. It should also be noted that pursuant to the Act, the insurer can refer 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 to mediation. Subsection 279(1) of the Act provides that such disputes shall be resolved in accordance with ss. 280 to 283 of the Act and the *Statutory Accident Benefits Schedule*. Pursuant to those sections of the Act, either the insured or the insurer may refer the issue in dispute to a mediator and, if the mediation fails, the parties jointly or the mediator may refer the issue in dispute to a person appointed by the Director for an evaluation of the probable outcome. If the issue is not thereby resolved, the insured may then bring a court proceeding, refer the issue to an arbitrator under s. 282, or the insured and the insurer may agree to submit the matter in dispute to any person for arbitration in accordance with the *Arbitration Act, 1991*, S.O. 1991, c. 17.

(5) Legislative history and intent

[26] I agree with the appellant that the evolution of the regulations governing payment for attendant care provided by family members and the five-year report on automobile insurance in Ontario released by FSCO shortly before SABS-2010 came into force support his argument that SABS-2010 was intended to provide a check on payments to family care-givers. However they do not, in my view, support the appellant's interpretation of s. 3(7) (e).

[27] Under the first Statutory Accident Benefits Schedule enacted by the government of Ontario – the *Statutory Accident Benefits Schedule–Accidents Before January 1, 1994*, R.R.O. 1990, Reg. 672, ("SABS-1990") – insurers were required to pay the amount of the gross income reasonably lost by a person other than the insured person as a result of the accident in caring for the insured person, to a maximum of $3,000 a month, and $500,000 with respect to each insured person. Insurers were not required to pay for attendant care provided by family members who did not lose income as a result of providing care: *Monachino v. Liberty* (2000), 47 O.R. (3d) 481.

[28] Section 47 of the next Statutory Accident Benefits Schedule enacted by the government – *Statutory Accident Benefits Schedule–Accidents After December 31, 1993 And Before November 1, 1996*, O. Reg. 776/93 ("SABS-1994") – provided for the compensation of family members of the insured person

who provided attendant care, without proof of loss of income. SABS-1996 continued this treatment of care-giving by family members.

[29] On March 31, 2009, FSCO released its first, five-year report on automobile insurance in Ontario. The report, which was mandated under s. 289.1 of the *Insurance Act*, summarized issues and concerns raised by stakeholders, and included recommendations aimed at improving the effectiveness and administration of the automobile insurance system.

[30] The appellant points to the concerns raised by the Insurance Bureau of Canada ("IBC") with respect to attendant care. At pages 44-45, FSCO reported that IBC indicated that over-utilization of the attendant care benefit was becoming a problem, with a 59.1 per cent increase in attendant care costs between 2004 and 2007. FSCO also reported anecdotal information from the insurance industry suggesting "that an increasing number of claimants with minor injuries are now claiming and receiving attendant care benefits". At page 45, FSCO expressed concern that assessments were being conducted "by individuals without explicit training in functional assessments to address functional impairment…" At page 46, it recommended that only occupational therapists and nurses who have been trained on the use of Form 1 should be permitted to assess auto accident victims for the attendant care benefit.[2] It concluded that, if adopted, this recommendation

[2] Subsection 39(1) of SABS-1996 provided that the Form 1 was to be prepared and submitted by "a member of a health profession who is authorized by law to treat the person's impairment."

should provide insurers with more confidence of the necessity of the attendant care claimed.

[31] At p. 47, FSCO also addressed the payment of attendant care benefits to family members:

> Another issue raised in the IBC submissions related to the payment of attendant care benefit to a claimant's family members and friends. Insurers are concerned that the benefit can become a windfall for the claimant if no actual services are provided….The IBC's solution is to restrict payment to family members only where it can be shown that an economic loss has been incurred.

[32] FSCO rejected IBC's solution:

> …The issue is not so much who is providing the care but whether care is actually required. FSCO believes that proper use of the Form 1 to screen claims is the most effective approach to ensuring that the benefit is paid to those who truly need the care. Introducing additional disability or functional eligibility tests or requiring caregivers to demonstrate economic loss would add more complexity to the system.

[33] SABS-2010, enacted without official commentary following the release of FSCO's report, required the Form 1 to be prepared by an occupational therapist or a registered nurse, and included the language at issue, requiring that the family care-giver have sustained an economic loss as a result of providing the attendant care services to the insured.

[34] IBC's "solution", as summarized by FSCO, did not include restricting the amount of the payment for attendant care to care provided during the period that the family care-giver would otherwise have been at work, as the appellant now proposes. Nor, based on FSCO's summary, did it propose reverting to the system in SABS-1990, which provided for reimbursement of income reasonably lost by a person other than the insured in caring for the insured, subject to maximums.

[35] In my view, the requirement adopted (that the family care-giver have sustained an economic loss) provides a rough check on attendant care costs.

[36] Attendant care benefits are only payable in respect of the provision by a family member of care detailed in the Form 1 assessment of the insured's attendant care needs if the family member sustains an economic loss as a result of providing such care to the insured. If an economic loss is sustained, attendant care benefits are payable with respect to all care detailed in the Form 1 provided by the family member, subject to the maximums in s. 19(3) and various other safeguards, including ss. 42 and 33 of SABS-2010. If no such loss is sustained, no attendant care benefits are payable in respect of care provided by the family member, even if the family member provides care that would otherwise be provided by someone in the course of their employment, occupation or profession and would necessitate the payment of attendant care benefits by the insured. And to the extent that the economic loss sustained by the family

member as a result of providing such care to an insured exceeds the maximum attendant care benefits stipulated in SABS-2010, the family member is not indemnified.

[37] It should be noted that the respondent has made significant progress, and no longer requires 24 hour care. Counsel advised that the respondent's mother has returned to work. While the mother continues to provide care to the respondent, she is no longer sustaining an economic loss as a result of providing care to the respondent. The respondent concedes that he is no longer entitled to attendant care benefits in respect of the care-giving services provided by his mother.

(6) Definition of "economic loss"

[38] The appellant argues that because "economic loss" is not defined in SABS-2010, insurers risk facing claims for attendant care benefits founded on wide and expansive interpretations of "economic loss", or *de minimis* financial or monetary loss.[3] If this transpires, it argues, the reduction in attendant care costs the legislature sought to achieve with SABS-2010 will not be achieved. The appellant urges the court to define "economic loss" for the purpose of SABS-2010. I would decline to do so. On the facts of this case, economic loss is clear.

[3] In *Simser v. Aviva Canada Inc.*, FSCO A11-004610, 2013 CarswellOnt 422, FSCO recently considered this issue.

The respondent's mother gave up full-time paid employment to provide care for her son on a 24-hour per day basis.

VI. ANALYSIS OF ISSUE TWO

[39] As indicated above, the appellant argues that the application judge erred in stating that the insurer must pay all of the expenses described in the Form 1. It must be noted that the appellant conceded that the full-time care described in the Form 1 was reasonable and necessary, and that the mother provided it. The statement by the application judge must be viewed in that light, and not as derogating from an insurer's right to challenge the assessment of an insured's attendant care needs reflected in the Form 1 pursuant to s. 42, or to request additional information from the insured pursuant to s. 33(1) of SABS-2010 to satisfy itself that the care was provided and the expense claimed was incurred.

[40] The three FSCO decisions that the appellant relies on – *Stargratt*, *McKnight* and *Fernandes* – involved disputes with respect to attendant care benefits governed by SABS-1996. SABS-1996 did not contain a definition of "incurred". At issue in each if these cases was whether the Form 1 created an automatic entitlement to payment.

[41] *McKnight* held that the insurer may in some cases require additional information pursuant to s. 33 of SABS-1996 to satisfy itself that the attendant care services were provided. Subsection 33(1) provides that a person applying

for a benefit under SABS-1996 shall, within 10 days after receiving a request from the insurer, provide the insurer with any information reasonably required to assist the insurer in determining the person's entitlement to a benefit. Substantially the same language is included in s. 33(1) of SABS-2010.

[42] In *Fernandes*, the insured sought recovery for the attendant care provided by family members, in addition to expenses paid to long term care facilities, in accordance with the Form 1. The Arbitrator found that only a small portion of the attendant care provided by family members was "reasonable and necessary" – a pre-condition in SABS-1996 which remains in SABS-2010. FSCO held that a Form 1 does not bind an arbitrator, and that the onus was on the insured to establish that the attendant care sought was reasonable and necessary. FSCO agreed with the arbitrator that the additional care provided by the family was neither reasonable nor necessary. *Fernandes* cited *McKnight*: SABS 1996 requires a benefit to be paid in accordance with the Form 1 only once entitlement to the benefits has been established.

[43] *Stargratt*, which preceded *McKnight*, commented in *obiter*, at para. 32, that insurers are entitled to require documentation of caregiver and attendant care services claimed.

[44] In my view, s. 33(1) of SABS-2010 and the three FSCO cases that the appellant relies on make clear that an insurer can request information to verify

that a family member has sustained an economic loss as a result of providing care to the insured, and, viewed in context, the application judge did not indicate to the contrary.

VII. SUMMARY, DISPOSTION AND COSTS

[45] In this case, the appellant does not challenge the Form 1, Assessment of Attendant Care Needs prepared in respect of the insured. That form established the need for 24 hour care and the amount payable for that care. As long as the care was provided and the family member who provided the care sustained an economic loss in so doing, the amount payable is not reduced only because the number of hours of paid employment forgone by the family member was fewer than the number of hours of care provided pursuant to the Form 1.

[46] I would accordingly dismiss this appeal. I would award costs to the respondent in the agreed amount of $17,402.32, inclusive of disbursements and applicable taxes.

Released: “AH” “JUL 16 2013”

“Alexandra Hoy J.A.”
“I agree Janet Simmons J.A.”
“I agree G.R. Strathy J.A.”