CITATION: Ontario (Health Insurance Plan) v. K.S., 2024 ONSC 2061
DIVISIONAL COURT FILE NO.: 559/23
DATE: 20240410

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

M. Edwards RSJ, Sachs and Davies JJ.

BETWEEN:	
THE GENERAL MANAGER, THE ONTARIO HEALTH INSURANCE PLAN Appellant	*Zachary Green* and *Emily Graham*, for the Appellant
– **and** –	
K.S. Respondent	*John McIntyre* and *Jessica Szabo*, for the Respondent
– **and** –	
EGALE CANADA Intervener	*Daniel Girlando* and *Stephen Chew*, for the Intervener
	HEARD at Toronto: February 27, 2024

Davies J.

REASONS FOR JUDGMENT

A. Overview

[1] K.S. has experienced significant gender dysphoria since adolescence. K.S.'s assigned sex at birth was male. She now identifies as non-binary, although female dominant.[1]

[2] In April 2022, K.S.'s physician submitted a request to the Ontario Health Insurance Plan ("OHIP") for funding for K.S. to have gender affirming surgery in Texas. K.S. requested funding

[1] K.S. uses she/her or they/them pronouns. K.S.'s counsel used she/her in their factum and when referring to K.S. during oral argument. For consistency, I will also refer to K.S. using she/her pronouns throughout these reasons.

for a vaginoplasty without a penectomy, which is also referred to as a penile preserving vaginoplasty.

[3] OHIP denied K.S.'s funding request because OHIP concluded that a vaginoplasty without penectomy is not a listed procedure in the Schedule of Benefits under the *Health Insurance Act*, R.S.O. 1990, c. H.6 and is, therefore, not an insured service. K.S. appealed OHIP's decision to the Health Services Appeal and Review Board (the "Board"). The Board granted K.S.'s appeal and found that vaginoplasty without penectomy is a listed service and, therefore, eligible for OHIP funding.

[4] OHIP appeals the Board's decision to this court. OHIP advanced three arguments on appeal.

[5] First, OHIP argued the Board erred in finding that vaginoplasty without a penectomy is specifically listed as an insured service in the Schedule of Benefits.

[6] Second, OHIP argued the Board erred in failing to consider that vaginoplasty without a penectomy is an experimental procedure in Ontario and, therefore, not eligible for funding.

[7] Finally, OHIP argued that the Board erred in finding the proposed surgery is eligible for funding without considering whether the other criteria for out of country coverage were met. This argument raises an issue that OHIP did not argue before the Board. OHIP argued for the first time in this court that even if vaginoplasty without penectomy is a specifically listed service, the surgery K.S. wants would still be ineligible for funding because services rendered outside Canada are only insured if they are "generally accepted by the medical profession in Ontario as appropriate for a person in the same medical circumstances as the insured person": R.R.O. 1990, Reg. 552 ("Regulation 552"), s. 28.4(2)(a). OHIP argues that because the surgery K.S. wants is experimental, it cannot meet the criterion in s. 28.4 of Regulation 552.

[8] For the following reasons, the appeal is dismissed.

B. Scope and Standard of Review

[9] Any party to a proceeding before the Board may appeal the Board's decision to the Divisional Court on a question of law, a question of fact or a question of mixed fact and law: *Health Insurance Act*, ss. 24(1) and 24(4). Because this is a statutory appeal, the appellate standards of review apply: *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, [2019] 4 S.C.R. 653, at para. 37, *Housen v. Nikolaisen*, 2002 SCC 33, [2002] 2 S.C.R. 235.

C. The Board hearing and decision

[10] In the June 2022 letter denying K.S.'s request for funding, OHIP stated as follows:

> Vaginoplasty (including penectomy, orchidectomy, clitoroplasty and labiaplasty) is an insured OHIP service when the criteria for payment is met, as set out in Appendix D to the Schedule of Benefits for Physician Services (the "Schedule"). Penile Preserving

> Vaginoplasty or Vaginoplasty (without penectomy) is not listed as a procedure in Appendix D of the Schedule. Therefore, this is not an insured service under OHIP. There are no provisions under the *Health Insurance Act* or its Regulations that permit OHIP to pay for an uninsured service or part of an uninsured service. For this reason the ministry cannot approve this request at this time.

[11] K.S. appealed that decision to the Board. K.S. gave three reasons for wanting a vaginoplasty without also having her penis removed. First, because she is non-binary and having her penis removed would invalidate her non-binary identity. Second, because of the risk of complications and urinary incontinence from the penectomy. Third, because of the risk of orgasm dysfunction if her penis is removed.

[12] K.S. argued that the vaginoplasty procedure she wants is identical to the process used to perform some vaginoplasties in Ontario. The only difference is she is not also asking to have an additional procedure, namely a penectomy.

[13] OHIP adduced evidence from Dr. Krakowsky, the medical lead for gender affirming surgery at Women's College Hospital in Toronto, at the hearing before the Board. Dr. Krakowsky is one of only a handful of surgeons who perform vaginoplasties in Ontario.

[14] In his report, Dr. Krakowsky explained there are three ways for a vaginoplasty to be performed. The most common surgical technique is penile inversion vaginoplasty in which the penis is removed and the penile tissue is used to construct the vaginal cavity, labia and clitoris. Dr. Krakowsky gave evidence that in some circumstances, an alternative approach is required. Dr. Krakowsky described two other techniques that are used when a penile inversion is not possible: peritoneal pull through vaginoplasty ("PPV") and rectosignmoid vaginoplasty ("RSV"). In both PPV and RSV procedures, non-penile tissue is used to construct the vagina and labia.

[15] Dr. Krakowsky testified that he has never performed a vaginoplasty without penectomy. Dr. Krakowsky opined that vaginoplasty without penectomy is considered experimental by most surgeons. Dr. Krakowsky explained that there is not enough current data to determine the efficacy of vaginoplasty without penectomy.

[16] K.S. argued before the Board that she was asking for funding to have a PPV or RSV, which are accepted surgical techniques for conducting a vaginoplasty. She argued that because her penile tissue is not needed to construct a vagina and labia in a PPV or RVS, her penis need not be and should not be removed.

[17] The Board found that vaginoplasty without penectomy is eligible for OHIP funding (assuming the insured person meets all the other conditions in the Schedule of Benefits for gender affirming surgery). The Board noted that paragraph 17 of Appendix D to the Schedule of Benefits lists vaginoplasty and penectomy as separate surgeries. The Board found that the term "vaginoplasty" in the Schedule of Benefits does not necessarily include a penectomy and is insured as a gender affirming surgery on its own. In reaching this conclusion, the Board also relied on the fact that Appendix D to the Schedule of Benefits makes explicit reference to the "World Professional Association for Transgendered Health (WPATH) Standards of Care that are in place at the time". The Board found that the Legislature must have intended the Schedule of Benefits to

be interpreted in a manner that is consistent with the WPATH Standards of Care, which encourage an individualized approach to gender affirming care.

[18] Having found that vaginoplasty without penectomy is a specifically listed service in paragraph 17 of Appendix D to the Schedule of Benefits, the Board found that it did not have to consider whether the treatment was experimental because the exclusion for experimental treatments does not apply to specifically listed services.

D. Did the Board err in law in finding that a vaginoplasty without penectomy is a specifically listed insured service in the Schedule of Benefits?

[19] Whether vaginoplasty without penectomy is "specifically listed" is a matter of statutory interpretation, which is a question of law that must be reviewed on a correctness standard.

[20] The basic rule of statutory interpretation is that the words of the legislation must be read in context and in their grammatical and ordinary sense. The words of the legislation must also be interpreted in a manner that is harmonious with the scheme of the Act and regulations, the object of the Act and regulations, and the intention of the Legislature: *Rizzo & Rizzo Shoes Ltd. (Re),* [1998] 1 S.C.R. 27, at para. 21, R. Sullivan, *Sullivan on the Construction of Statutes* (5th ed. 2008), at p. 1, citing E. A. Driedger, *The Construction of Statutes* (1974), at p. 67. To find an interpretation that is harmonious with the legislative scheme, the court must conduct a "textual, contextual and purposive analysis": *Canada Trustco Mortgage Co. v. Canada*, 2005 SCC 54, [2005] 2 S.C.R. 601, at para. 10. When the provision in question is precise and unequivocal, courts should give effect to the ordinary meaning of words used. If, however, the words of the provision can support more than one meaning, the court can look to the object, spirit and purpose of the provision as well: *Canada Trustco Mortgage Co. v. Canada*, 2005 SCC 54, [2005] 2 S.C.R. 601, at paras. 10 and 47. Finally, if the legislative provision in question is open to different but equally plausible interpretations, the Court should prefer the interpretation that is consistent with *Charter* values: *Bell ExpressVu Limited Partnership v. Rex*, 2002 SCC 42, [2002] 2 S.C.R. 559, at para. 62.

[21] This appeal turns on the meaning of Part B of paragraph 17 of Appendix D to the Schedule of Benefits, which deals with gender affirming surgery and forms part of Regulation 552 under the Act. Before turning to the language of the relevant portion of Appendix D, it is necessary to briefly describe the structure of the OHIP funding scheme.

[22] OHIP pays for insured medical services for residents in Ontario. "Insured services" include medically necessary services rendered by physicians as may be prescribed by regulations: Act, ss. 1, 11.2(1) and 12. A service rendered by a physician in Ontario is an insured service if it is "referred to in the schedule of benefits and rendered in such circumstances or under such conditions as may be specified in the schedule of benefits": Regulation 552, s. 37.1(1). Additional requirements must be met if funding is sought for the service to be provided outside the country.

[23] The Act, through its regulations, also contains a long list of services that are not insured. For example, s. 24(1)(17) of Regulation 552 states that treatment for a medical condition that is generally accepted as experimental in Ontario is not an insured service "unless, in the case of services rendered by physicians, they are specifically listed as an insured service or as part of an

insured service in the schedule of benefits." In other words, if a service is "specifically listed" in the schedule of benefits, the exclusion for experimental services does not apply.

[24] OHIP argues that the Board erred in finding that vaginoplasty without penectomy is "specifically listed" in the schedule of benefits. OHIP further argues that because vaginoplasty without penectomy is not specifically listed, the Board was required to consider whether it is excluded under s. 24(1) because, according OHIP's expert, it is an experimental treatment for gender dysmorphia.

[25] In my view, the Board was correct to find that vaginoplasty without penectomy is "specifically listed" in the schedule of benefits for three reasons. First, the Board's interpretation is consistent with the grammatical and ordinary meaning of the relevant provisions. Second, the Board's interpretation is consistent with the Legislature's intention. And third, if there is any ambiguity in the language of the provision, the Board's interpretation is consistent with *Charter* values.

a. The Board's conclusion is consistent with the grammatical and ordinary meaning of the relevant provisions

[26] To understand why the Board's decision that vaginoplasty without penectomy is "specifically listed" is consistent with the grammatical and ordinary meaning of the relevant provisions, it is necessary to set out the provisions of the Schedule of Benefits under Regulation 552 to the Act in some detail.

[27] Paragraph 17 of Appendix D to the Schedule of Benefits states:

> Sex-reassignment surgical procedures listed in this section are insured services when prior authorization has been obtained from the [Ministry of Health].
>
> A request for prior authorization must be submitted with an assessment that recommends the surgery.

[28] Part B of paragraph 17 of Appendix D to the Schedule of Benefits sets out the specific requirements "sex-reassignment" surgery to be approved. The relevant portion reads as follows:

> Prior authorization for sex-reassignment surgery will only be provided when the following requirements have been met and only <u>for the specific services listed:</u>
>
> 1. <u>External Genital Surgery (clitoral release, glansplasty, metoidioplasty, penile implant, phalloplasty, scrotoplasty, testicular implants, urethroplasty, vaginectomy, penectomy, vaginoplasty)</u>
>
>   a. Two supporting assessments from appropriately trained providers confirming that the patient is an appropriate candidate for surgery as follows:
>
>   i. One assessment from a physician or nurse practitioner; and

ii. One assessment from a different physician, different nurse practitioner, registered nurse, psychologist, or regulated social worker; and

b. The supporting assessments confirm that the insured person meets all of the following criteria:

i. Has a diagnosis of persistent gender dysphoria;

ii. Has completed twelve (12) continuous months of hormone therapy (unless hormones are contraindicated);

iii. Has completed twelve (12) continuous months of living in a gender role that is congruent with their gender identity; and

iv. Is recommended for surgery. [Emphasis added.]

[29] There is no dispute that K.S. submitted the required assessments and meets the criteria for external genital surgery. The question is whether the type of surgery K.S. wants and her medical team recommends – vaginoplasty without penectomy – is "specifically listed" as an insured service in Part B of paragraph 17 of Appendix D to the Schedule of Benefits.

[30] OHIP agrees that vaginoplasty is a category of surgery that is eligible for funding in some circumstances. However, OHIP argues that just because vaginoplasty is listed, that does not mean every type of vaginoplasty or every procedure for performing a vaginoplasty must be funded. OHIP argues that although "vaginoplasty" is included in the categories of procedures in paragraph 17 of Appendix D, "vaginoplasty without penectomy" is not specifically listed and is, therefore, not insured. OHIP adduced evidence at the hearing before the Board that vaginoplasties without penectomy are not performed in Ontario. Dr. Krakowsky testified that vaginoplasties without penectomy is considered experimental in Ontario because there is no peer-reviewed literature on when would be appropriate and no long-term data on the psychological or physical outcomes of such procedures. OHIP argues it would be absurd to conclude that the Legislature intended to include an experimental procedure in the list of insured services.

[31] I do not agree with OHIP's position. In essence, OHIP is asking this court to find that although the Legislature decided to list vaginoplasty as a separate, stand-alone procedure in the list of surgeries in paragraph 17 to Appendix D, the Legislature intended only one type of vaginoplasty – vaginoplasty with penectomy – to be insured.

[32] OHIP's position is inconsistent with the plain meaning of the provision.

[33] In Part B of paragraph 17 of Appendix D to the Schedule of Benefits vaginoplasty and penectomy are listed separately:

> Prior authorization for sex-reassignment surgery will only be provided when the following requirements have been met and only <u>for the specific services listed:</u>

2. External Genital Surgery (clitoral release, glansplasty, metoidioplasty, penile implant, phalloplasty, scrotoplasty, testicular implants, urethroplasty, vaginectomy, penectomy, vaginoplasty) [Emphasis added.]

[34] The comma between each procedure suggests they are discrete, separate procedures that are eligible for funding if the conditions for prior approval are sought. The preamble describes them as "specific services." The plain, grammatical meaning of the preamble and the list, as drafted, is that each of the listed surgeries is eligible for funding on its own with prior approval. The fact that most people who have a vaginoplasty have it done in a way that also involves a penectomy does not change the plain and grammatical meaning of paragraph 17 of Appendix D.

[35] If the Legislature intended to limit the availability of OHIP funding to vaginoplasties that are performed as a penile inversion vaginoplasty or otherwise at the same time as a penectomy, it would have drafted the list in paragraph 17 differently. Contrary to the submission of counsel, this issue is not simply a matter of how the surgery is performed. Some vaginoplasties involve a penectomy if they are done using the penile-inversion method and the penile tissue is used to construct the vagina and labia. However, some vaginoplasties are performed using non-penile tissue. In those cases, a penectomy is not required to conduct the vaginoplasty. If the Legislature intended to only fund sex-reassignment vaginoplasties that also involve a penectomy (either as part of the vaginoplasty or otherwise), it could and should have used limiting language in the list of external genital surgeries that are eligible for funding.

b. The Board's interpretation is consistent with the Legislature's intent

[36] The Board's conclusion that the term "vaginoplasty" means "vaginoplasty without penectomy" is also consistent with the Legislature's decision to incorporate the World Professional Association for Transgendered Health (WPATH) Standards of Care in paragraph 17 of Appendix D.

[37] Someone seeking funding for gender affirming surgery is required to submit two assessments confirming they are an appropriate candidate for surgery. Part B of paragraph 17 of Appendix D states that the assessments must be done by a medical service provider "trained in assessment, diagnosis, and treatment of gender dysphoria in accordance with the World Professional Association for Transgendered Health (WPATH) Standards of Care that are in place at the time of the recommendation."

[38] The WPATH Standards of Care recommend that health care professionals provide non-binary people with "individualized assessment and treatment that affirms their non-binary experiences of gender." The WPATH Standards of Care expressly refer to vaginoplasty without penectomy as a surgical option for some non-binary people:

> Additional surgical requests for nonbinary people [assigned male at birth] include penile-preserving vaginoplasty, vaginoplasty with preservation of the testicle(s), and procedures resulting in an absence of external primary sexual characteristics (i.e. penectomy, scrotectomy, orchiectomy, etc.).

[39] The WPATH Standards of Care also contain a list of gender affirming surgical procedures. That list includes "Vaginoplasty (inversion, peritoneal, intestinal)". The note accompanying vaginoplasty in the WPATH Standards of Care says the procedure "may include retention of penis and/or testicle."

[40] The Board was correct to find that by referencing the "WPATH Standards of Care in place at the time of the recommendation" in Appendix D to the Schedule of Benefits, the Legislature must have intended the Schedule of Benefits to be interpreted in a manner that is consistent with those standards as they evolve. The WPATH Standards of Care in place at the time K.S. made her request for funding support an interpretation of paragraph 17 of Appendix D that allows non-binary individuals, with the support of their WPATH trained provider, to select from among the listed surgeries, including a vaginoplasty without a penectomy.

[41] OHIP's interpretation of paragraph 17, which limits funding to those who are seeking a vaginoplasty with penectomy, is inconsistent with the WPATH Standards of Care which recommend individualized treatment plans for non-binary people that affirm their experience of gender.

c. The Board's interpretation is consistent with Charter values

[42] Given my conclusion that the Board's interpretation is correct based on a plain reading of the Schedule of Benefits, I do not need to address the *Charter* arguments made by K.S. and supported by the intervener. However, if there was an ambiguity in the language of Part B of paragraph 17 of Appendix D to the Schedule of Benefits, the Board's interpretation is also consistent with *Charter* values of equality and security of the person.

[43] The *Charter*-protected right to security of the person safeguards individual dignity and autonomy. Our law has long protected a patient's freedom to make decisions about their healthcare and bodily integrity: *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331, at paras. 64-67. Section 15 of the *Charter* guarantees every individual the right to equal treatment before and under the law, and the right not to be discriminated against based on enumerated and analogous grounds.

[44] The Supreme Court of Canada has recognized that the history of transgender and other gender non-conforming people in Canada has been marked by discrimination and disadvantage. The Supreme Court noted that transgender people occupy a unique position of disadvantage in our society, particularly in relation to housing, employment and healthcare: *Hansmand v. Neufeld*, 2023 SCC 14, at paras. 84-86.

[45] I find that interpreting Part B of paragraph 17 of Appendix D to the Schedule of Benefits in a way that requires transgender or non-binary people assigned male at birth to remove their penis to receive state funding for a vaginoplasty would be inconsistent with the values of equality and security of the person. Such an interpretation would force transgender, non-binary people like K.S. to choose between having a surgery (penectomy) they do not want and which does not align with their gender expression to get state funding, on the one hand, and not having gender affirming surgery at all, on the other. Such a choice would reinforce their disadvantaged position and would not promote their dignity and autonomy.

d. Conclusion

[46] I find the Board was correct to find that a vaginoplasty without an accompanying penectomy is a "specifically listed" service in the Schedule of Benefits.

[47] OHIP seems to accept that if a vaginoplasty without penectomy is a specifically listed service, the exclusion in s. 24(1)(17) of Regulation 552 for experimental treatments does not apply. In its factum, OHIP argued that if the Board was wrong and vaginoplasty without penectomy is not specifically listed, it would then be excluded as an insured service because it is considered experimental in Ontario. I agree that, as a matter of statutory interpretation, the exclusions in s. 24(1) of Regulation 552 only apply to services that are not "specifically listed." Given my finding that the Board was correct to find that a vaginoplasty without penectomy is specifically listed, I need not address OHIP's second argument that the Board erred in failing to find that the surgery K.S. wants is excluded under s. 24(1)(17) of Regulation 552 because it is experimental.

E. Did the Board err in failing to consider whether vaginoplasty without penectomy is a generally accepted procedure?

[48] OHIP argues that even if the Board was correct to find that vaginoplasty without penectomy is specifically listed and, therefore, not excluded under s. 24(1)(17) of Regulation 552 because it is experimental, the Board erred in finding that the surgery K.S. seeks is eligible for funding. OHIP argues the Board failed to consider whether the other criteria for out-of-country funding were met.

[49] On an appeal, the Board has the power to direct the General Manager of OHIP to take such action as the Board considers the General Manager should take in accordance with the Act and the regulations: Act, s. 21(1). OHIP argues the Board exceeded its jurisdiction by ordering the General Manager to fund K.S.'s surgery without considering the other eligibility criteria.

[50] Regulation 552 contains additional eligibility requirements for services provided outside Canada to be insured. Section 28.4(2)(a) of Regulation 552 says that services rendered at a hospital outside Canada are prescribed as insured services if "the service is generally accepted by the medical profession in Ontario as appropriate for a person in the same medical circumstances as the insured person." OHIP now argues K.S. should be denied funding because she cannot meet the criteria for obtaining funding to have surgery out of the country.

[51] The difficulty with OHIP's position is that OHIP did not but could have raise the application of s. 28.4(2)(a) of Regulation 552 before the Board. OHIP filed two submissions with the Board in support of its denial of funding to K.S. Initially, OHIP defended its conclusion that vaginoplasty is not a listed service. OHIP first argued that K.S.'s requested surgery was not covered by Part B of paragraph 17 of Appendix D because those provisions deal with "sex-reassignment surgery" and the surgery K.S. wants will not result in a reassignment from one sex to another. In its supplementary submissions OHIP raised an alternative argument for denying K.S. funding, namely that vaginoplasty without penectomy is not an insured service because it is considered experimental in Ontario and, therefore, excluded under s. 24(1)(17) of Regulation 552. In support of its supplementary argument, OHIP filed expert evidence from Dr. Krakowsky. This supplementary argument – that vaginoplasty is an excluded service because it is considered

experimental – was not articulated in OHIP's June 2022 letter denying K.S. funding. In other words, OHIP understood it could raise new issues before the Board to defend its decision to deny funding to K.S.

[52] It was clear in K.S.'s request for funding that she was seeking funding for the surgery to be performed outside of Canada. If OHIP believed that s. 28.4(2)(a) of Regulation 552 was also a basis to deny K.S. funding, it could have raised that before the Board. Having not raised it as an issue, OHIP cannot now fault the Board for failing to consider it.

[53] The remaining issue is whether we should allow OHIP to raise this issue for the first time on this appeal. While appellate courts generally do not entertain new issues on appeal, we have the discretion to consider an issue raised for the first time on appeal if it is in the interests of justice to do so and if the issue can be fairly addressed on the record from the Board: *Kailman v. Graham,* 2009 ONCA 77, 245 O.A.C. 130, at para. 18.

[54] I am not satisfied it is in the interests of justice to allow OHIP to raise a new issue on appeal for at least three reasons.

[55] First, OHIP had an opportunity to raise this issue before the Board to defend the denial of funding.

[56] Second, the record from the hearing before the Board does not fully and fairly address OHIP's argument about the application of s. 28.4(2)(a) of Regulation 552. Whether vaginoplasty without penectomy is excluded under s. 28.4 of Regulation 552 is a question of mixed fact and law. I do not agree with OHIP's submission that the exclusion under s. 28.4 of Regulation 552 is functionally equivalent to the exclusion for experimental procedures. What is considered "experimental" is not necessarily the same as what is generally accepted as appropriate for a person in the same medical circumstances as K.S. An experimental procedure could be generally accepted as appropriate for a person in some circumstances. The fact that the legislature chose to use different language in ss. 24(1) and 28.4 of Regulation 552 suggests, as a matter of statutory interpretation, that the tests are different under the two provisions. OHIP did not adduce evidence on whether a vaginoplasty without penectomy is generally accepted as appropriate for patients in K.S.'s position. The focus of Dr. Krakowsky's report and his *viva voce* evidence was on whether vaginoplasty without penectomy is considered experimental. Dr. Krakowsky was not asked to opine on whether vaginoplasty without penectomy would be generally accepted as appropriate for someone in K.S.'s position. As a result, K.S. was not given an opportunity to cross-examine OHIP's expert on this issue or to adduce evidence in response.

[57] Third, OHIP has not adequately explained why it did not raise the application of s. 28.4(2)(a) of Regulation 552 before the Board. While there will be circumstances in which it is appropriate to allow an appellant to raise a new issue on appeal, to do so routinely will encourage piecemeal litigation which undermines the fairness and efficiency of the process.

[58] I, therefore, decline to exercise my discretion to allow OHIP to raise a new issue on appeal.

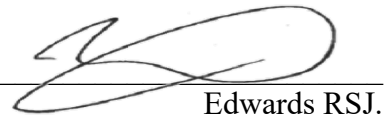
F. Disposition

[59] OHIP's appeal is dismissed.

[60] Based on the agreement of counsel, OHIP is ordered to pay K.S. her costs of the appeal, fixed in the amount of $20,000.

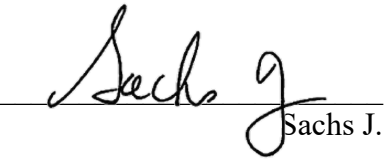
Davies J.

I agree



Edwards RSJ.

I agree



Sachs J.

Date: April 10, 2024

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ONTARIO

SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

M. Edwards RSJ, Sachs and Davies JJ.

BETWEEN:

THE GENERAL MANAGER, THE ONTARIO HEALTH INSURANCE PLAN

Appellant

– **and** –

K.S.

Respondent

– **and** –

EGALE CANADA

Intervener

REASONS FOR JUDGMENT

DAVIES J.

Date of Release: April 10, 2024