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| **THE NEW POWER OF THE** |
| **DISABILITY CERTIFICATE** |

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**INTRODUCTION**

Given the legislative overhaul which occurred in September of 2010, a more apt title for this paper could be “The Old Power of the Disability Certificate”.

The best way of appreciating the significant changes which occurred on September 1, 2010, concerning the “specified benefit”[[1]](#footnote-1) determination procedure, is to compare and contrast the procedures adjusters must follow in assessing an insured person’s entitlement to benefits.

**Old SABS (Pre Sept. 1/10)**

**37.** (1) If an insurer wishes to determine if an insured person is still entitled to a specified benefit, the insurer,

(a) **shall** request that the insured person submit within 15 business days a new disability certificate completed as of a date on or after the date of the request; **and**

(b) may notify the insured person that the insurer requires the insured person to be examined under section 42.

**New SABS (Post Sept. 1/10)**

**37.** (1) If an insurer wishes to determine if an insured person is still entitled to a specified benefit, the insurer **may**, but not more often than is reasonably necessary,

(a) request that the insured person submit, within 15 business days, a new disability certificate completed as of a date on or after the date of the request;

(b) notify the insured person that the insurer requires an examination under section 44; **or**

(c) do both.

*The section 37 procedure has moved from a mandatory process to a permissible one.* In fact, a strict reading of section 37 suggests that an adjuster could terminate a specified benefit even without having an IE assessment report or a Disability Certificate.

In order to appreciate the significance of the new regime concerning Disability Certificates, it is important to review the principles that applied concerning the evaluation of an injured person's disability before September 2010. These principles were concisely listed by the Director's Delegate in the decision of Yogesvaran v. State Farm[[2]](#footnote-2). *The importance and lingering effect of this decision cannot be ignored as many of you may still have claims in litigation for which these principles continue to have direct application.*

The issue in the Yogesvaran decision was how "new" a new Disability Certificate had to be when an insurer was evaluating an injured person's entitlement to benefits. Prior to September 1, 2010, when an insurer wished to assess whether a person continued to be entitled to a specified benefit, the insurer had to request a "new Disability Certificate". When Ms. Yogesvaran submitted her Application for Accident Benefits in May 2007, she included a Disability Certificate from her family doctor stating that he anticipated her to be disabled from work and housekeeping chores for nine to twelve weeks. On August 14, 2007, some twelve weeks after the date of the first Disability Certificate, State Farm requested a new Disability Certificate. The second Disability Certificate, dated August 30, 2007, anticipated a further nine to twelve weeks of disability.

On December 5, 2007 and December 13, 2007, State Farm had Ms. Yogesvaran undergo occupational therapy and physiatry IE assessments. In January 2008, State Farm denied Ms. Yogesvaran housekeeping and income replacement benefits based on the IE assessors’ opinions.

Ms. Yogesvaran's counsel brought an application for a preliminary issue challenging the procedure the adjuster followed in assessing his client’s continued entitlement to the specified benefits. Ms. Yogesvaran argued that the determination procedure was flawed as the adjuster failed to request a new Disability Certificate before arranging the IE assessments. Ms. Yogesvaran succeeded with this preliminary issue, and the insurer appealed the decision. In dismissing the insurer's appeal, the Director's Delegate set forth a number of important principles:

1. “An insurer’s ongoing adjusting of a file must comply with the *Schedule*. The principles of consumer protection and utmost good faith reinforce this precept.” [p. 9]
2. “Subsection 37(1) is not ambiguous as to what is required of an insurer. For an insurer to determine continuing entitlement to a specified benefit, two courses of action are available. One is strictly mandatory. An insurer “shall” request that the insured person submit a “new” disability certificate. “New” means completed as of a date on or after the date of the request. An insurer’s second available course of action is that contemporaneous (as indicated by the use of the word “and,” not “or”) with the mandatory requirement of requesting a new disability certificate, the insurer has discretion to also notify the insured person that it requires the latter to be examined under section 42.” [emphasis added] [p. 9]
3. “The insurer cannot rely on an out-of-date disability certificate in determining whether an insured person is still entitled to specified benefits.” [p. 10]
4. “That an insured’s failure to provide a requested disability certificate would result, by itself, in termination of benefits, while an insurer turning a blind eye to this provision would have no consequence, would seem unjust and unacceptable and, as stated by the Arbitrator, render clause 37(1)(a) meaningless.” [p. 10]
5. “Insurers who break the rules should not be given an advantage over insurers who follow them.” [p. 12]

Many of these principles, of course, continue to apply today, regardless of the changes which took effect on September 1, 2010.

While many in the insurance industry may argue that Ms. Yogesvaran succeeded because of an insurer’s mere technical breach of the Old SABS, from my perspective, the principles set out in Yogesvaran are appropriate and sensible. If the insurer is going to require an insured person to undergo an IE assessment, it is only reasonable that the insurance assessor be provided with up-to-date information from the insured person's healthcare provider. How can an IE assessor fairly evaluate an insured person's entitlement to a specified benefit if this assessor does not have the pertinent and current information, such as that provided in a Disability Certificate:

* a description of the injuries suffered in the accident;
* the healthcare provider's opinion about whether the insured person is entitled to the specified benefit;
* whether the healthcare provider believes that the person may be able to return to modified hours or duties;
* whether the insured person has undergone any recent “examinations, investigations or consultations”;
* whether further "examinations, investigations or consultations" are being considered by the healthcare provider; and,
* an up-to-date description of any medication which the insured person is taking for accident-related injuries?

It would only seem reasonable that the insurance assessor be provided with this important information before he/she is called upon to express an opinion as to whether the insured person is entitled to the specified benefit. Furthermore, any adjuster making a good faith specified benefit determination would require this information as well.

**DISABILITY CERTIFICATE – PRE AND POST SEPTEMBER 1, 2010**

The New SABS not only changed the procedure adjusters must follow in assessing an injured person’s entitlement to specified benefits, but the Disability Certificate form itself also changed.

The New SABS Disability Certificate asks for the following additional information:

* whether the injured person is currently working;
* when was the last date that the injured person worked;
* whether the injured person was working at the time of the accident, and, if so, what kind of work he/she was performing;
* whether the injured person was the primary caregiver for anyone at the time of the accident; and,
* whether the injured person was enrolled in an educational program at the time of the accident.

For whatever reason, the new Disability Certificate does not contain the section pertaining to people who were unemployed at the time of the accident, but had worked at least 26 of the 52 weeks before the collision (or were collecting employment insurance at the time of the accident).

**ADJUSTER DUTIES**

The AB adjuster has a number of good faith obligations which, in my view, necessitate that she request an updated Disability Certificate as part of the specified benefit determination process.

* A first-party insurer must approach a claim with an open mind and assess it fairly and not as a potential adversary. An insurer must carefully consider all of the available information, giving appropriate weight in a fair and even-handed manner.[[3]](#footnote-3)
* The aim of first-party adjusting is not to find reasons, however flimsy, to deny a claim.[[4]](#footnote-4)
* A first-party insurer must conduct a reasonable investigation of the information presented to it, identify what additional information may exist that would assist in assessing the claim and notify its insured of any additional information it reasonably required to assess the claim.[[5]](#footnote-5)
* A first-party insurer must reassess the validity of a claim as new information is received.[[6]](#footnote-6)
* An insurer is required to provide “meaningful reasons” in denying a claim so that the insured person may determine whether there were any errors in the insurer’s information or its analysis.[[7]](#footnote-7)
* Simply relying on a report will not necessarily be sufficient to protect an insurer from a special award. For instance, in *Graper* v. *Liberty Mutual Fire Insurance Company*, (FSCO A00-000133, July 20, 2001), it was found that the insurer’s selective reading of its own experts’ reports supported a special award.
* The standard expected of an adjuster is one of sound and moderate judgment.[[8]](#footnote-8)

With these responsibilities in mind, recall what questions the insured person’s healthcare provider is required to address in the Disability Certificate:

* A description of injuries and sequelae that are a direct result of the MVA;
* Date of most recent examination;
* Whether the insured person can return to work on modified hours and/or duties;
* Anticipated duration of disability;
* Whether there have been any examinations, investigations or consultations not previously reported;
* Whether there are further examinations, investigations or consultations contemplated or required; and,
* Listing of medications the insured person is taking for accident-related conditions.

Any adjuster acting in good faith *should* want to have answers to these important questions before determining whether the insured person is entitled to a specified benefit.

The importance of having a current Disability Certificate is underscored in the preamble of the form itself: "The health practitioner’s opinion will be relied upon by people who review the certificate to make important decisions. Accordingly, it is necessary to be accurate and complete." [emphasis added]

**SECTION 37 PROCEDURE**

Since September 1, 2010, it is clear that adjusters may terminate an insured person's entitlement to a specified benefit without requesting a new Disability Certificate or arranging an IE assessment. This is a radical departure from the days of Designated Assessment Centers, mandatory “new” Disability Certificates, and mandatory section 42 assessments. Section 37 now cloaks the adjuster with much more power in determining “if an insured person is still entitled to a specified benefit”, in that the adjuster “may” request a new Disability Certificate or arrange a section 44 assessment or do both.

With this added power comes added responsibilities. Adjusters will be expected to adjust claims: to consider what information is missing; to obtain and consider relevant information; and, to thoroughly and critically assess evidence regarding impairment and benefit entitlement (and not just the IE assessment report).

Examples of an insurer not carrying out these adjusting responsibilities can be found in the Arbitration decision of Cowans v. Motors Insurance.[[9]](#footnote-9) The issue in Cowans, at least initially, was whether Mr. Cowans was entitled to post-104 week IRBs. Just prior to the hearing, the insurer consented to an order reinstating Mr. Cowans’ IRBs, together with interest. The issue at the hearing, therefore, was whether Motors Insurance was required to pay a Special Award.

Arbitrator Wilson commenced his decision by remarking that “… Mr. Cowans’ claims bring into question the way Motors and perhaps other insurers deal with the determination of entitlement to benefits in a post-DAC world and how the system of insurer’s assessments that replace the DAC system fits into such determinations.”

In Cowans, Arbitrator Wilson found that the adjuster delegated his adjusting responsibilities to Health Impact Multidisciplinary Assessment Centres – an assessment company retained to perform IE assessments. The adjuster admitted that he “simply acted on the recommendations of the assessors”. He testified, further, that he took the expert reports at “face value”. He assumed that “being professionals the experts would do their jobs properly”. The adjuster “assumed that all relevant information was taken into consideration” by the IE assessors. In commenting on the adjuster’s decision to “delegate” (abdicate?) benefit determination to the IE assessors, the Arbitrator stated, “while the assessment protocols relied upon by Motors may well be common in the industry they are not a substitute for a balanced and considered determination by an insurer.”

Arbitrator Wilson rejected the adjuster’s testimony that he had read the IE reports thoroughly or critically:

“I suspect that he engaged in the same process as outlined [in another adjuster’s] report: a short review of conclusions followed by a decision to adopt the recommendation of the most favorable report.”

Arbitrator Wilson found that the adjuster simply ignored information or opinions which contradicted those expressed by the IE assessors.[[10]](#footnote-10) He noted that an adjuster is to consider all evidence, not just the opinions of the IE assessors:

“Likewise, an insurer in making a determination cannot ignore credible evidence that is available to it. An insurer has an obligation to assess and critically examine these opinions, and not simply pretend that they do not exist. To repeat, as O’Connor J. noted in 702535 Ontario Inc. *v.* Non- Marine Underwriters, Lloyd’s of London: “In making a decision whether to refuse payment of a claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner.” I do not accept that it is reasonable to ignore or discount credible information that merely disagrees with preconceptions or conclusions already made.”

Later in his decision, Arbitrator Wilson pointed out that delegating benefit determination to IE assessors exposes insurers to potential punitive damages or Special Awards:

“Simply papering” a termination by obtaining a compliant report from an assessor is not necessarily a protection against a special award if an insurer closes its mind to other information potentially available to it that might have cast its decision or actions in doubt.” [emphasis added]

Arbitrator Wilson even focused on the fact that adjusters are required to make “determinations” which “suggests that the legislators have high expectations of the insurer’s decision-making process”. He observed, furthermore, that there was a “systemic” problem with the benefit determination process, in that many adjusters simply parroted the IE assessors’ opinions without thought or reflection. These IE assessors see such a large volume of people that it is foolish to assume that they are assessing all available evidence in a thoughtful and critical manner:

“Whether Dr. Finkel was biased or prejudiced or not, I find that it tests credulity to believe that an assessment mill such as described by Dr. Finkel could ever generate meaningful results.”

Toward the end of his decision, the Arbitrator reminds the reader that post-104 determination is a legal one, and not based solely on medical opinions:

“It should be remembered that disability in accident benefit matters is a legal test, albeit one which usually requires medical input. Making a determination requires the application of the medical evidence – all the available medical evidence to the legal test. Since it is the Insurer who makes the determination, it is incumbent upon an insurer to critically review the available evidence and to apply it to the test for entitlement contained in section 5(2) of the Schedule.”

In Cowans, Arbitrator Wilson concluded that the insurer’s conduct was “egregious” and awarded a Special Award of 40% of the withheld benefits.

**CONCLUSION (What goes around comes around?)**

Over the decades, insurers have been forced to follow different procedures when determining whether an insured person is entitled to benefits. We started with a system where the adjusters made the decisions, and there were little pre-litigation safeguards (OMPP). Next, followed the system of Disability Certificates and Designated Assessment Centres (Bill 164 and early Bill 59). Prior to September 1, 2010, we had a system where adjusters were forced to request a new Disability Certificate (whether they read and considered it is another issue) and arrange an IE assessment. Today, we have a system where adjusters can make benefit determinations without requesting a new Disability Certificate or an IE assessment for that matter.

Unfortunately, the current system provides no meaningful pre-litigation safeguards for the insured person. It appears that adjusters are operating in a “business as usual” manner. They typically do request a new Disability Certificate, but at the same time, arrange an IE assessment. Sometimes, the IE assessment proceeds before the deadline has passed for the healthcare provider to submit a new Disability Certificate. This manner of scheduling sends a clear message that the adjuster assigns little, if any, weight to the Disability Certificate.

Mr. Cowans and his counsel should be commended for pursuing his matter through to the end in the litigation process. The Cowans decision is important - not because the insurer’s behavior was so egregious - but because it is so sadly common.

1. Section 36 of the SABS defines “specified benefit” as “an income replacement benefit, non-earner benefit, caregiver benefit or a payment for housekeeping or home maintenance services under section 23. [↑](#footnote-ref-1)
2. *Yogesvaran* v. *State Farm* (FSCO P09-00942, October 28, 2010) (Blackman) [↑](#footnote-ref-2)
3. *Wawanesa Mutual Insurance Co.* v. *Melchiorre et al.,* FSCO P07-00014) (Blackman) [↑](#footnote-ref-3)
4. *Wawanesa Mutual Insurance Co.* v. *Melchiorre et al.*, FSCO P07-00014 (Blackman) [↑](#footnote-ref-4)
5. *Wawanesa Mutual Insurance Co.* v*. Melchiorre et al.*, FSCO P07-00014 (Blackman) [↑](#footnote-ref-5)
6. *Wawanesa Mutual Insurance Co.* v. *Melchiorre et al.*, FSCO P07-00014 (Blackman) [↑](#footnote-ref-6)
7. *Wawanesa Mutual Insurance Co.* v. *Melchiorre et al.*, FSCO P07-00014 (Blackman) [↑](#footnote-ref-7)
8. *Plowright* v.*Wellington Insurance Co.* (OIC A-003985, October 29, 1993) [↑](#footnote-ref-8)
9. *Cowans* v. *Motors Insurance Corporation (* FSCO A-09-003237, October 15, 2010) [↑](#footnote-ref-9)
10. My cynical side wonders whether adjusters ever actually read (let alone consider) the new Disability Certificates they were once forced to request. Anyone reading this paper can likely count, on one hand, the number of times an adjuster has accepted the opinion of a healthcare provider over that expressed by an IE assessor. [↑](#footnote-ref-10)