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THE INDUSTRY OF THE LIVING DEAD:

A Critical Look at Disability Insurance

DAVID SCHULZE*

RÉSUMÉ

L'industrie de l'assurance fait référence à l'invalidité à long terme comme s'il s'agissait d'une situation de mort vivant, puisque, selon l'opinion des actuaire, cela est pire que la mort. Ainsi, la personne handicapée est privée de revenu mais a des dépenses de subsistance similaires ou plus élevées à celles d'une personne qui n'est pas handicapée. Cet article étudie le sort de personnes handicapées qui sont obligées de laisser le monde du travail. Il étudie également le dossier de l'industrie de l'assurance, la gestion des sinistres, la non-observation des règlements de la cour, la philosophie de la gestion des sinistres, l'utilisation des prestations versées par le gouvernement, la réglementation du Surintendant des assurances et la nécessité d'une réforme au sein de cette industrie.

INTRODUCTION

Anne Corr's 27-year career as a nursing assistant ended one day in January 1980 when she had a heart attack while lifting a patient. Not only was her heart left functioning at about half its normal capacity, her doctors prescribed a regular course of medication that included a diuretic, which caused frequent and uncontrolled urination, a potassium supplement causing diarrhoea and Valium, which she said left her dazed and a little "high."

* Copyright © 1993 David Schulze. David Schulze received his LL.B from Osgoode Hall Law School, Toronto, 1993. He is currently completing a Bachelor of Civil Law at L'Université de Montréal. The author would like to thank the staff and students at Parkdale Community Legal Services in Toronto for giving him the opportunity to learn about these issues first hand in the spring semester of 1992. Special thanks are due to Sheila Cuthbertson for her inspired and inspiring supervision.

When Anne Corr applied for early payment of her death benefit under the disability instalment provision of the group plan at the Fishermen's Memorial Hospital in Lunenburg, Nova Scotia, the London Life Insurance Company turned her down. In the company's view, Corr did not qualify as

“totally and permanently disabled by accident, injury or disease, so as to be permanently continuously and wholly prevented thereby from engaging in any occupation and from performing any work for compensation or profit for the remainder of [her] life....”

This paper is about an industry that made it necessary for Corr to appear before the Nova Scotia Supreme Court's Trial Division in order to receive the \$30,000 owed to her under the policy.¹

II. THE PATCHWORK OF DISABILITY INCOME PROGRAMS

The insurance industry refers to long-term disability as “living death,” since in the actuarial view it is worse than dying: the disabled person is deprived of income but left with the same or higher living expenses as an able-bodied person.² For a large number of disabled people, their physical condition also means a life of economic deprivation: a 1986 survey found that 63 percent of the disabled had annual incomes of less than \$10,000 and a labour force participation rate in 1983-84 of only 48 percent, compared to a national average of 75 percent.³

This paper considers the fate only of those whom disability has forced to leave the work force, but it is important to remember there are many more who have never been able to enter it. The Social Assistance Review Committee estimated that a comprehensive disability insurance system for wage-earners in

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1. *Corr v. London Life Insurance Co.*, (1983) 3 C.C.L.I. 232 (N.S. S.C. [T.D.]). It should be said that Anne Corr's doctor reported she could return to light work, as the president of the Canadian Life and Health Insurance Association was anxious to point out in his reply to my article “Disability insurance? Just try to collect” *The [Toronto] Globe and Mail* (2 April 1993). See: Mark R. Daniels, “There's a duty to pay only legitimate claims” *The Globe and Mail* (3 May 1993). However, given all her other symptoms and that her doctor also admitted she had discomfort performing ordinary daily activities, it is unclear why the insurer should have accepted this view so readily.
 2. Canada, Status of Disabled Persons Secretariat, *Obstacles: Recommendations formulated and progress assessed by the Special Committee on the Disabled and the Handicapped* (Ottawa: Secretary of State, 1985) at 83.
 3. Canada, Secretary of State, *Profile of Disabled Persons in Canada* (Ottawa: 1986) at 18-20, cited in Sherri Torjman, *Income Insecurity: The Disability Income System in Canada* (Toronto: G. Allan Roeher Institute, 1988) at 5.

Ontario would benefit fewer than 25 percent of the 90,000 disabled recipients of social assistance.⁴ In addition, only an estimated 43 percent of Canadian workers are covered by private group disability insurance plans.⁵

If impairment of a psychological or physical function forces a wage-earner to leave the labour market, she has very few guarantees of income replacement, though the list of potential sources is extensive. A worker in Ontario may be eligible under any of the following publicly-created plans: Workers' Compensation benefits; Veteran's disability pensions; Canada Pension Plan (CPP) disability benefits; Unemployment Insurance (UI) sick benefits; statutory no-fault automobile insurance benefits delivered by private insurers; Criminal Injuries Compensation Board benefits; the Guaranteed Annual Income System for the Disabled (GAINS-D) from social assistance.

In addition, a disabled worker may have the right to sue if she was the victim of negligence or assault; to claim a disability pension under a private pension plan; to receive benefits from a life insurance policy in regular but limited instalments under a disability provision (as Anne Corr attempted to do); to receive benefits under a private long- or short-term disability insurance plan.

Most wage-earners are eligible for benefits from the Workers' Compensation Board, but only when they suffer their injuries in the course of employment and Paul Weiler has argued the scheme tends to miss those suffering from disease, as opposed to victims of traumatic injury.⁶ The most readily available of the other disability benefits are those offered by the Canada Pension Plan. All employed and self-employed persons who have made sufficient contributions are eligible, with the contributory period adjusted to include those kept out of the labour force temporarily by disability or childrearing.

But recipients are not entitled to CPP disability benefits until they are suffering from a "severe and prolonged mental or physical disability" which is "of indefinite duration" or likely to be fatal and which renders them "incapable of regularly pursuing any substantially gainful occupation."⁷ This strict

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4. Ontario, *Report of the Social Assistance Review Committee: Transitions* (Toronto: Queen's Printer, 13 May 1988, at 103-104 (Chair: G. Thomson) [hereinafter *Transitions*]).
 5. Canada, Joint Federal-Provincial Study of A Comprehensive Disability Protection Program, *Stage III Report: Program Design Options* (Ottawa: Health and Welfare Canada, 1985) at 1, as cited in *Transitions* at 107.
 6. C. Weiler, *Protecting the Worker from Disability: Challenges for the Eighties* (Toronto: Ministry of Labour, 1983) at 10, 16, 50, 56-57.
 7. *Canada Pension Plan*, R.S.C. 1985, c.C-8, s.44.

definition of disability precludes those capable of recovery and thus precludes the program having a rehabilitative purpose.⁸

The CPP disability benefits are also not particularly generous, with a maximum level in 1991 of \$743.64 per month.⁹ Yet the most recent study of recipients illustrates that though inadequate, the benefits are essential to their incomes. The maximum benefit was only \$216.06 per month in 1980 (or \$2,592.72 annually), but the benefits were their recipients' main source of support in 1979 and counted for 32 percent of the group's total income, which averaged only \$7,082.¹⁰

III. THE INSURANCE INDUSTRY'S RECORD

One might imagine that the obvious inadequacy of public disability benefits and the insurance industry's own view of disability as "living death" would spur it to the speedy processing of claims. Unfortunately, the experience of Anne Corr suggests that, if anything, the opposite is true. When Justice Coulter Osborne investigated automobile insurance in Ontario in 1988, he reserved some of his harshest words for the private insurer's performance in delivering disability benefits to accident victims:

"The insurance industry's performance in this area is nothing short of abysmal. I concede at the outset that there are some insurers who do deliver disability benefits reasonably promptly; most do not."¹¹

The provision of these benefits has been studied because automobile insurance has been the subject of intense political debate and law reform in Ontario during the past 15 years and disability benefits are now part of the compulsory, no-fault coverage required in automobile insurance policies under Ontario statute.¹²

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8. A study of public long-term disability programs in eight industrialized countries found only Canada and the United Kingdom required a total inability to earn income and only their plans had no linkage to providers of vocational rehabilitation: Ilene R. Zeitzer and Laurel E. Beedon, "Long-Term Disability Programs in Selected Countries," (September 1987) *50 Social Security Bulletin* at 13, 15.
 9. L. E. Coward, *Mercer Handbook of Canadian Pension and Benefit Plans* (North York: CCH Canadian Limited, 1991) at 189.
 10. Health and Welfare Canada, *Research Note*, No. 1 (1982), "Survey of Canada Pension Plan Disability Benefit Recipients."
 11. Ontario, *Report of the Inquiry into Motor Vehicle Accident Compensation in Ontario*, (Toronto: Ministry of Financial Institutions, 1988) vol. 1 at 166.
 12. *Insurance Act*, R.S.O. 1990, c.I.8, pt. VI [hereinafter the Act].

By contrast, very little investigation has been done into the practices of companies providing other forms of disability coverage. The scattered evidence on their performance provides no reason to believe disability insurers are any more diligent, though most are life insurance companies which are wealthier and better-capitalized than the general (or property and casualty) insurers writing automobile policies. The Ontario Superintendent of Insurance reported to a Legislative Assembly committee in 1981 that it had received some 80 complaints about accident and sickness insurance the previous year, largely related to the termination and refusal of disability claims.¹³ A Canadian Life and Health Insurance Association spokesman admitted to *Maclean's* in 1987 that among the 250 written complaints received concerning its member companies in 1986, the most common complaint was about "health claims—and by far the most difficult is disability."¹⁴

A study of reported disability insurance cases suggests an industry actively resisting claims which the courts later uphold. A search of cases in the Dominion Reports Service database dealing with disability insurance, but not with automobile or motor vehicle insurance, generated 61 common law cases from 1969 to 1989. In and of itself, this is disturbing: industry statistics indicate 5.525 million Canadians were insured under long-term disability policies in 1989. Even accounting for disputes settled through other means and before actions went to court, the number of cases litigated suggests a very low rate of appeal of insurance company decisions. The comparable CPP disability benefit, to which roughly twice as many Canadians are entitled, generated 11,226 appeals from refusals in 1987 alone.¹⁵ This seems to indicate the discouraging effect of requiring legal action as the final appeal, compared to a cost-free publicly-run process.

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13. Ontario, Select Committee on Company Law, *The Insurance Industry; Fifth Report on Accident and Sickness Insurance* (Toronto: Legislative Assembly, 1981) at 122.
 14. Diane Francis, "The tangle of disability claims" (14 December 1987) 100 *Maclean's* 11.
 15. Canadian Life and Health Insurance Association, *Canadian Life and Health Insurance Facts* (Toronto, 1991) at 45; Canada, *House of Commons Debates* (18 April 1988).

TABLE I

Cases on Disability Insurance from The Dominion Reports Service,
1969-1989

<i>Total cases:</i>	65	
less	4	civil law cases
	6	cases not involving insurer
<i>Total sample:</i>	55	
less	6	cases in which insurer was plaintiff (10.9 %)
sub-total:	49	cases in which insured party was plaintiff (89.1%)
less	5	procedural decisions
sub-total:	35	successful actions by insured plaintiffs (79.5 %)
	9	unsuccessful actions (20.5 %)

In summary, the sample of cases suggests litigation over disability benefits is overwhelmingly commenced by the potential beneficiaries, who are overwhelmingly successful in court. Excluding six cases in which the disability insurer was not a party (wrongful dismissal, tax and family law cases), left a sample of 55 cases. The insurers were the plaintiff in only six: two of subrogation and four in which they sued beneficiaries to recover disability payments (only two of these were successful). The insured party was the plaintiff suing for benefits in fully 49 cases, principally under employer-sponsored group plans, but also individual and credit insurance policies; these plaintiffs won in 35 cases and lost in only nine (the remainder were on procedure). This success rate is striking in view of the vast difference in resources between insurance companies, many of whom have staff counsel and retain the most expensive private firms, while the claimants largely live on low, limited incomes.

As will be illustrated below, a qualitative examination of the cases makes it impossible to attribute the high success rate for plaintiff beneficiaries simply to a process of self-selection, in which only the most justified claims are litigated.

IV. "LITIGATE, ARBITRATE, SETTLE OR SURRENDER": THE MANAGEMENT OF PRIVATE DISABILITY INSURANCE CLAIMS

1. How insurers administer claims

The cases reveal a consistent pattern of bad faith in the insurers' treatment of disability claimants. All of the following cases were won by the plaintiff beneficiaries:

- A claims officer at Crown Life Insurance determined a pharmacist's severe hearing impairment had not permanently disabled him based on a single telephone conversation.¹⁶
- Mutual of Omaha offered a 51-year-old former janitor in Vancouver a job as a security guard in another city, though he suffered from chronic obstructive lung disease, took heavy medication, used a respirator, and tired after walking more than a block.¹⁷
- Great-West Life denied long-term disability benefits to a woman suffering from a condition her doctors had difficulty diagnosing, but which they were sure was organic in origin. It left her suffering from excess sweating, shivering, chills, headaches, nausea and vomiting, fatigue, weakness and shortness of breath. A psychiatrist hired by the company determined its cause was her neurotic personality after a single examination.¹⁸
- National Life received a report from an independent rehabilitative medicine specialist that a claimant with degenerative disc disease had chronic pain which was an "over-response" and needed rehabilitation. The company then advised her solicitor it would not release its medical reports and that they contained little evidence she was totally disabled. Instead, an officer of the company offered her a lump-sum settlement, since her problem "can be summarized by saying that she has become accustomed to collecting disability benefits and probably does not want to go back into the work force in any capacity."¹⁹

16. *Malkin v. Crown Life Insurance Co.* (1989), 56 D.L.R. (4th) 296 (B.C.S.C.).

17. *Braun v. Mutual of Omaha Insurance Co.*, [1987] I.L.R. 1-2181 (B.C. S.C.).

18. *Snook v. Great-West Life Assurance Co.*, [1990] I.L.R. 1-2634 (B.C.S.C.). Not reported in the judgment is the fact that the diagnosis—which the trial judge called "superficial"—was essential to terminating benefits because the policy covered organic sickness and psychosis, but not psychoneurotic or behavioural disorders: "Undiagnosed illness held to be organic in origin" (Sept. 1990) 10 Decisions (Canadian Health and Life Insurance Association) 3 at 4.

19. *Wright v. National Life Assurance Co. of Canada* (1987), 25 C.C.L.I. 1 (Ont. S.C.).

- Mutual of Omaha received a report from an independent medical examiner that a mechanic who had been backed up onto by a truck should receive retraining for a trade which would not require him to sit or stand for long periods. "I appreciate these restrictions are severe and might fail," the doctor wrote. "That should be kept in mind regarding disability payments." The company then advised the claimant it no longer considered him totally disabled, but would pay him one more year's benefits if he agreed to follow a rehabilitation program.²⁰
- Imperial Life ignored two independent medical assessments that the owner of a hairdressing salon was totally disabled after developing an ossification of the muscles in his leg and resulting pain. Instead, it hired a rehabilitation consultant who determined he could work in telephone marketing or as a host in a restaurant or lounge, though he had learned English as an adult and had a Grade Five education; she based this conclusion on the availability of government programs to modify workplaces for the disabled.²¹

A recently closed file at Parkdale Community Legal Services provides further evidence of the insurance industry's methods. The client was a nursing assistant who left her job because of severe rheumatoid arthritis. Following a medical examination, the doctor selected by the insurer reported to the company:

"I see this lady as being genuinely, medically, necessarily and totally disabled from performing the essential duties of her former occupation outlined in the job duty statement form. [...]"

I see this lady as an excellent candidate for a rehabilitation or retraining program to some lighter duty employment. But I am only able to say this is possible because her arthritis has been quiet for the last 6 months.

One can best judge the future in rheumatoid arthritis by what has gone [on] in the past. And the time of successful treatment is only 6 months, therefore it is difficult to make any hard statements."

Citing the policy's requirement that she be "totally disabled from any occupation," the insurer terminated her benefits one month later. A claims analyst wrote to her: "The medical information that we have on file does not clinically support a disability severe enough to render you totally disabled as defined above."²²

20. *Savoie v. Mutual of Omaha Insurance Co.*, [1988] I.L.R. 1-2302 (Ont. H.C.).

21. *Mercuri v. Imperial Life Assurance Co. of Canada*, [1990] N.B.J. No. 711 (Q.B.).

22. Parkdale Community Legal Services, File No. 370013. A settlement was eventually negotiated by the clinic after the threat of litigation.

The insurer's view of claimant service was revealed by the fate of the Paul Revere Life Insurance Company agent who took the side of one his clients, Mr. Sucharov, in a disability insurance claim. The company chose to fire the agent long before Sucharov's case had wound its way to the Supreme Court for a decision in his favour²³ but exactly three months before his pension would have vested. The trial judge found the company's "real reason" for the firing had been the agent's support for his client's successful legal action.²⁴

2. ATTRITION BY LITIGATION: DISABILITY INSURERS IN COURT

Consistent with the abusive treatment, the concealment and blatant distortion of information illustrated in the cases cited above, reported decisions also repeatedly reveal insurance companies' wilful disregard for their claimants' true situations when denying or terminating benefits. The following cases were also lost by the insurers:

- Both Laurentian Imperial and Imperial Life Assurance (related companies) argued that claimants suffering from schizophrenia were not entitled to benefits because they did not comply with a clause requiring regular care by a psychiatrist, even though the rejection of medical treatment is a symptom of the illness.²⁵
- The Metropolitan Life Insurance Company argued the fact that a man suffering from a degenerative back disease did some consulting work proved he was not totally disabled, though he did so in considerable pain and against his doctor's orders, because he needed to earn a living.²⁶
- Co-Operative Fire and Casualty maintained that a 42-year-old stenographer whose chronic back pain made her unable to stand or sit for longer than 30 minutes was still able to perform the duties of an occupation for which she was reasonably qualified.²⁷
- Paul Revere Life Insurance argued that an internist who had worked 90 hours per week before undergoing a triple bypass operation was not partially disabled because he could still perform every duty of his work,

23. *Paul Revere Life Insurance Co. v. Sucharov*, [1983] 2 S.C.R. 541.

24. *Mahon v. Paul Revere Life Insurance Co.* (1983), 19 Man. R. (2d) 388 (Q.B.).

25. *Seitz v. The Laurentian Imperial Co.*, [1993] I.L.R. 1-2912 (Ont. Ct. G.D.); *Kirkness Estate v. The Imperial Life Assurance Co. of Canada*, [1993] 1-2923 (Ont. C.A.)

26. *Hiscock v. Metropolitan Life Insurance Co.* (1989), 223 A.P.R. 126 (Nfld. S.C.).

27. *MacEachern v. Co-Operative Fire and Casualty Co.* (1987), 75 N.S.R. (2d) 271 (S.C.).

although he was now restricted to no more than 50 hours of work per week.²⁸

- Canada Life Assurance argued that a factory worker with a Grade Nine education and a degenerative disorder of the spine aggravated by a back injury, was not totally disabled from work for which he was fitted by training or experience, because he had attempted to sell jewellery and lost \$7,200 on the venture, and had attempted to drive a truck and a front-end loader, but gave it up because it caused him pain.²⁹

These cases indicate the irrelevance of judicial decisions to insurance company practices. In particular, the grounds for these disputes over the claimants' total disability are not merely specious, but show a blatant disregard for the Canadian courts' definition of the term. According to a leading author:

"It has been established law that 'total disability' does not mean that the insured must be totally helpless, and that even the ability to perform some duties of his own occupation, or another occupation not commensurate with his education, training or experience will not disqualify the insured from benefits.

The distinction is not between total disability and partial disability, but between total disability and no disability at all."³⁰

The effect this disregard for established case law can have on a claimant is illustrated by an open file at Parkdale Community Legal Services: the client suffered a physical injury at work in December 1990. He was scheduled for the second of two operations to deal with it in September 1991, when his doctors learned he had angina and cancelled the surgery. Within weeks the client applied for long-term disability benefits based on the injury, but was refused by the insurer because the 90-day period in which to submit a claim had expired in March 1991.

This constituted the requirement of an impossibility: the client could not know that his injury had permanently disabled him until he developed angina; in March he was expecting an operation to remedy it.³¹ Moreover, the courts had excluded such impossible requirements as long ago as 1940, ruling that an insurance claim is not invalidated by a failure to give notice within a specified

28. *Paul Revere Life Insurance Co. v. Dufton*, [1989] I.L.R. 1-2413 (B.C.S.C.).

29. *Campbell v. Canada Life Assurance Co.* (1990), 45 C.C.L.I. 73 (Man. C.A.).

30. D. Norwood, "Issues in Disability Insurance," (1986) 3 C.J.I.L. 115.

31. Parkdale Community Legal Services, File No. 250035.

time period, if it could not have been given then, and is submitted as soon as is reasonably possible.³² The client received his benefits only after intervention by the clinic, which included the threat of litigation.

If the insurers show little regard for rulings from the courts, the courts for their part have been extremely deferential to the insurance companies. The only real penalty ever assessed against their claims-processing practices is costs on the punitive solicitor and client scale, even though the courts have now decided claims for tortious damages can be considered under a contract for insurance. In *Thompson v. Zurich Insurance Co.*,³³ Pennell J. held that insurance is not actually a commercial contract, but rather for "peace of mind," the security of knowing one is protected. Thus, he opened the door to punitive damages against an insurer, but all but slammed it shut again by requiring "evidence of malice," which exceeded "mere negligence or want of sound judgment or hasty action."³⁴

The result, points out Michael Kelly, has been that termination of benefits based on weak or insufficient evidence has been held not to be enough to ground punitive damages. He concludes:

"Given the lack of success of punitive damages claims in disability insurance litigation, it would seem that Canadian courts consider it acceptable for an insurer to challenge an individual's ongoing claim of disability by terminating benefits and thus force the claimant to bear the risk and expense of bringing a lawsuit."³⁵

In one case, even when National Life ignored a doctor's recommendation of rehabilitation, kept the report from the claimant's solicitor and accused the claimant of being unwilling to return to work, the company was found not to have acted in bad faith.³⁶

32. *Price v. Dominion of Canada General Insurance Co.*, [1940] 8 I.L.R. 215 (N.B. T.D.), reversed on other grounds [1941] 7 I.L.R. 351 (C.A.), reversed [1941] 8 I.L.R. 207 (S.C.C.). See also: *Grant v. British Pacific Life Insurance Co.*, [1980] I.L.R. 1-1225 (N.S. T.D.); *Vogt v. Paul Revere Life Insurance* (1977), 43 A.P.R. 249 (N.S. T.D.).

33. (1984), 45 O.R. (2d) 744.

34. *Ibid.* 753.

35. M. W. Kelly, "Taking on the Terminator: Issues to Consider When Suing a Disability Insurer" [1992] 14 Adv. Q. 308 at 317.

36. *Wright v. National Life Assurance Co. of Canada* (1987), 25 C.C.L.I. 1 (Ont. S.C.).

3. DISABILITY BENEFITS AS LOSSES AND SURRENDERS: THE INSURERS' GENERAL THEORY OF CLAIMS MANAGEMENT

By their own words, insurance companies have demonstrated there is more than an administrative problem in how claims are dealt with: insurers are philosophically opposed to paying claims as submitted. An explicit statement of this can be found in a commentary on the decision in *Thompson v. Zurich Insurance Co.* in an industry publication in 1986 by J.C.W. Thompson, a manager at the Mortgage Insurance Company of Canada (which does not provide disability insurance).³⁷ In face of a claim, he wrote, an insurer's choices are to "litigate, arbitrate, settle, or surrender."

According to Thompson: "Insurance companies are mostly forced into litigation by, first, excessive amounts claimed and, second, by issues of principle which cannot be ignored." Arbitration as used in the construction industry was a model he hoped the insurance industry would eventually adopt. Settlement was only possible with a "valid claim" and a "reasonable quantum for the injury or damage to the claimant." But the real danger, he wrote, was surrender:

"The reason I included 'surrender' in the title as an alternative to 'settlement' is because very often the constraints, real or imagined, experienced by an insurance company cause it to surrender to a claim rather than negotiate a fair and reasonable settlement or deny it.

One example of this is where a claim (however lacking in merit) is for a sum which would preclude litigation because of high legal costs, [and] is disposed of by an *ex gratia* payment to avoid irritation and administrative personnel waste."³⁸

For Thompson, then, paying a claim as submitted is inherently a surrender and paying the amount claimed could by definition not be a "fair and reasonable settlement."

Under this philosophy, the claimant has not merely the onus the courts impose of establishing her entitlement to benefits, but actually has the benefit of the doubt applied against her. Thompson explained:

"...There is undoubtedly much evidence in the files of insurance companies to indicate a public propensity to (a) make invalid claims and (b) ask for more than the injury is worth.

...

37. J.C.W. Thompson, "Litigate, Arbitrate, Settle—or Surrender?" (March 1986) 91 *Cdn. Insurance* 17.

38. *Ibid* 18.

These experiences undoubtedly originate and maintain the adversary aspects of claims negotiation and the unenthusiastic wariness of which insurance companies and their personnel are often accused in responding to claims".

Thompson was also keen to point out the difference between private insurers' methods and "the enormously costly aberrations apparent in federal and provincial social welfare programmes." The point was well-taken since one means by which private plans maintain lower costs is by not indexing benefits to inflation, unlike public schemes, which are regularly adjusted. Yet it is hard to find any expression of concern in the insurance industry that permanently disabled claimants might therefore be condemned to a steadily declining standard of living.

There is more to the insurance industry's approach to claims: in their own terminology they refer to a claim payment as a "loss." Health insurers report their "earned loss ratio" as the ratio of claims and adjusting expenses paid, relative to the premiums earned. The inaccuracy of this description can best be understood by recalling that an insurance company is fundamentally a financial institution: if its actuarial calculations are correct, an insurer should not pay out any more in claims than it earns in premiums and therefore no more runs a loss than a bank whose clients withdraw as much money as they deposit. By the time individual claims are paid, the company has had the opportunity to earn its profits through the investment of premiums. Moreover, the reported figure for claims established each year actually includes a reserve for payments in all future years, on which the company then earns interest.³⁹

The financial counterpart to Thompson's philosophy of claims processing was offered by Daniel Damov, president and chief executive officer of the Travelers Life Insurance Co. of Canada in a 1987 speech to his colleagues.

"Think of the fact that on most group lines, over 90 per cent of premiums are paid in losses and that the expected profit margin may be one per cent or less. It means that if losses are overpaid by one percentage point, this wipes out the profit. And how much is one per cent? Well, it could be one week, more or less, on a two-year disability claim. It could be 75 cents on a prescription drug claim for \$75.00, and so on."⁴⁰

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39. G. N. Watson and B. R. Ouimet, "Elements of Group Insurance," in *CLU Textbook Library* (Don Mills: The Institute of Chartered Life Underwriters of Canada, 1984) at 6-11.
40. D. Damov, "Is Group Insurance in Canada Profitable?" (1987) 8 *Cdn. J. of Life Insurance* 19 at 21.

Damov explained his company had "alerted the entire organization to pay close attention to the responsibility of loss management." His speech makes it clear where the description of an approved claim as a "loss" must lead: profits can only be maintained at the expense of the beneficiaries. A week of benefits for a disabled person is not her right under the policy, but an attack on the insurer's profitability and should, if possible, be avoided.

Even if one were to accept Damov's and the industry's formulation that claims paid are "paid in losses," the total "earned profit" for publicly-traded Canadian accident and sickness insurers in 1990 remained very healthy at 10.08 percent. This means that \$389.6 million of the \$3.5 billion they earned in premiums was left over after they had paid all the claims, including reserves for future benefits. The companies also earned a further \$613.7 million in investment income. The break-down for privately-held insurers is not available, but the industry as a whole earned over \$5 billion in premiums while paying out only \$4.3 billion in benefits in 1990.⁴¹

V. CLAIMS MANAGEMENT FOR BEGINNERS: THE ROLE OF THE EMPLOYER

Standing between the insurers and the individual beneficiaries is another actor involved in the administration of group plans: the employer. Insurers actively seek to involve employers, beginning by almost invariably requiring them to contribute to the premiums.

For both the disabled worker and the public purse, the consequences of this requirement are perverse: employer contributions to a private health insurance plan are always deductible as a business expense, but for employees they are neither taxable nor deductible at the time the premium is paid. So long as the employer has contributed any part of the premium, however, benefits become taxable when paid to disabled workers, who only then may deduct their previous contributions to the plan (unadjusted for inflation).⁴²

Given the unfortunate tax consequences for employees and employers' desire to avoid spending money, one might well wonder why employer premium contributions are required at all. An underwriter's textbook explains that they help make the plan more economically attractive to employees less likely to

41. "1990 Accident and Sickness Results," 58 Cdn. Underwriter (June 1991) 40 at 40; Canadian Life and Health Insurance Association, *Canadian Life and Health Insurance Facts* (Toronto, 1991) at 45.

42. *Income Tax Act*, S.C. 1970-71-72, c.63., ss.6(1)(f), 118.3(1).

benefit from it, absorb cost fluctuations from year to year, but most importantly:

“[Contributions] give the employer a financial stake in the plan. This will ensure his active interest in the operation of the plan. Not only will this tend to ensure careful and proper administration, which is important for the success of any plan, but it will help to eliminate abuses of the plan by certain employees.”⁴³

Giving the employer as “active” an interest as the insurer in the policy, then, means establishing it as an intermediary to discourage claims.

A number of cases suggest employers can obstruct a disabled worker’s claims as readily as the insurer: A case currently under litigation by Parkdale Community Legal Services alleges Mount Sinai Hospital is liable to a nursing assistant whom it repeatedly failed to provide with an application for a private insurer’s long-term disability benefits, during a five-year period when it had proof of her condition.⁴⁴ In *Tarailo v. Allied Chemicals Ltd.*,⁴⁵ the Ontario High Court of Justice held an employer liable to an employee after it discharged him because of unacceptable behaviour caused by his mental illness, but failed to assist him in making a claim for long-term disability benefits under its group plan.

The courts have also found insurers vicariously liable for employers’ conduct, which can be advantageous for employees who actually reach court. In *Tarailo* the insurer was found equally liable with the employer whom it had made its agent for the completion of claims forms, but who did not even have a copy of the master policy available.⁴⁶ In *London Life Insurance Co. v. Baker*,⁴⁷ the employer both mistakenly collected premiums from the claimant before he was eligible for coverage and assured him he was covered during a lay-off longer than allowed under the policy. The court held the plaintiff employee was covered because the employer, a family-owned firm with only five

43. *Supra*, note 39 at 6-13.

44. Statement of Claim, *Maria Dimov v. Mutual of Omaha Insurance Company and Mount Sinai Hospital* (20 December 1991), Ontario Court (General Division), Court File No. 91-CQ-11778.

45. (1989), 68 O.R. (2d) 288 (H.C.J.), which followed *Int’l. Brotherhood of Teamsters v. Taylor-Read Enterprises* (1980), 109 D.L.R. (3d) 653 (B.C.S.C.). An appeal of the decision in *Tarailo* was settled on consent: (1992), 7 O.R. (3d) 318.

46. *Ibid.* at 297, 302.

47. (1987), 34 D.L.R. (4th) 340 (N.S.C.A.).

seasonal employees, was poorly informed about group insurance by London Life's representative.

But given their role as poorly informed agents, it is at least as likely that employers will actively but mistakenly discourage employees from seeking benefits to which they are entitled, as they will mistakenly attempt to provide benefits to which employees are not entitled. Even if the courts have not generally allowed the insurers to shift their liability to the employers,⁴⁸ the cases demonstrate they have shifted the responsibility for claims administration, with sometimes damaging results.

VI. REDUCING RISKS AND PAYMENTS: ACCESS TO PRIVATE DISABILITY BENEFITS

1. The contract

Claims "negotiation" and "loss management" are not the only ways in which the insurance companies maintain their profitability: they have always designed contracts to keep their liability to a minimum.

"Confinement clauses" were common in the past and set stringent conditions that allowed insurers to cancel benefits when they were not met. Typically, they required something such as a "disability... which confines the Insured continuously within doors and requires regular visits therein by [a] legally qualified physician."⁴⁹ A claimant who had to leave the house to see his doctor and went out for short walks was no longer "necessarily, strictly and continuously confined to his house" and no longer entitled to benefits.⁵⁰ Their effect appears to have been severe enough that since 1973, under statute, confinement clauses are no longer binding on the insured in Ontario.⁵¹

48. Richard B. Hayles predicts "no court will exonerate an insurer in an actual case" of error by a group insurance intermediary "because of the harsh effect such a decision would have on the employee beneficiary" if the employer could not provide the benefits: "Group Insurance: Agency Status of the Master Policyholder" (1991-2) 3 C.I.L.R. 305 at 313.

49. *Kruger v. Mutual Benefit Health and Accident Association*, [1944] O.R. 157 (C.A.).

50. *Continental Casualty Company v. Roberge*, [1955] S.C.R. 576 (my translation of the clause from the French).

51. Incredibly, even after this amendment the Court upheld a confinement clause in a contract continuously renewed between 1955 and 1976: *Zappone v. Mutual of Omaha Insurance Co.*, [1983] I.L.R. 1-1708 (Ont. S.C.), [1987] I.L.R. 1-2145 (Ont. C.A.).

Currently, the most important use of contracts is to restrict access to disability insurance. Insurers simply refuse to insure entire classes of workers whose occupations they believe are too hazardous. For instance, an underwriter's textbook on group insurance suggests they should decline to provide accident and sickness plans to groups of employees working for hospitals and sanatoriums or for taxicab companies.⁵²

After discovering in the late 1980s that about 25 percent of claims on individual policies were based on "burnout and nervous breakdown," Constellation Assurance Company began screening out professionals with "possible stress, combined with a dicey blood chemistry test" which would suggest drug abuse. A vice-president of the company explained it was "too difficult to exclude these conditions on the policy itself...."⁵³

But insurers often rely on exclusionary clauses to exclude certain members from group disability benefits. A person with AIDS complained to the Ontario Human Rights Commission that his employer's group plan from North American Life, which excluded conditions treated during the first 90 days of employment (a standard clause particularly in contracts with small groups), was effective discrimination on the basis of a handicap. But a Board of Inquiry upheld the exclusion as reasonable and *bona fide* because the discrimination was based on "sound insurance practice."⁵⁴

The Board of Inquiry upheld the clause because its aim was to prevent adverse selection of the plan by those most likely to need its benefits, a danger it held was probably higher among small groups, even though North American Life failed to make a statistically viable case for the clause's success in achieving that aim. The decision also held that the clause reduced the potential risk to which the insurer was exposed. Not surprisingly, none of nine alternatives proposed by the complainant was found to fully replace these legitimate aims. Curiously, however, the decision held that the clause should not apply so as to exclude coverage for those with pre-existing handicaps whose increased risk to the insurer was not as "lamentably high and substantial" as that resulting from an HIV infection.

Adverse or anti-selection—where group members are allowed to pick the coverage most beneficial to themselves—has always been something under-

52. *Supra*, note 39 at 6-20.

53. As cited in Betty Lee, "Planning for Disaster" (July 1989) 62 *Cdn. Business* 71 at 75.

54. "Exclusion from coverage of pre-existing handicap ruled not discriminatory" (November 1992) 12 *Decisions* (Canadian Life and Health Insurance Association) 6 at 7-8; "Insurance-AIDS" (1 December 1992) *Canadian Press Newstex*.

writers were instructed to avoid when writing group policies.⁵⁵ A lawyer for North American Life commented during the complaint's investigation, that an order to provide coverage to those already ill "would undermine the whole basis of insurance as a risk selection process."⁵⁶ But "risk selection process" is merely another way of expressing the exclusion from group coverage of precisely those individuals most likely to need an insurance plan's benefits.⁵⁷ By recognizing this practice as "reasonable and *bona fide*," the Board of Inquiry's decision (currently under appeal) upheld selection as a privilege exclusively reserved for insurers.

Finally, the contract almost invariably limits the insurer's potential liability to a claimant through the "all-source maximum." Under this standard provision, not only are payments to the disabled worker limited to a fixed dollar amount, but her replacement income including all other sources may not be more than a fixed percentage of pre-disability earnings (generally 85 percent of gross or 75 percent of after-tax earnings).⁵⁸ If necessary, payments by the insurer will be reduced to ensure the total amount of disability income remains at this limit. As two industry consultants recently pointed out, this means that even an employee who collects from the plan "will have paid a premium for a benefit amount that will never be received...."⁵⁹

2. The State as primary payer

Disability insurers also maintain their profits by exploiting public programs: contracts usually include clauses providing for the deduction from a claimant's benefits of any payments received under plans such as Workers' Compensation or CPP. These are the other sources the all-source maximum is generally meant to catch.

55. *Supra*, note 39 at 2-3.

56. As cited in N. Bamm, "Untrodden Paths" (October 1991) 15 *Benefits Canada* 11 at 11.

57. Another lawyer for North American Life, showing more colour than tact, told the press: "You can't insure a burning building." See: "AIDS-Firing," (7 January 1992) *Canadian Press Newstex*.

58. An intriguing use was recently made of the all-source maximum in a case currently under appeal: the plaintiff successfully argued her CPP benefits should not be deducted from her disability insurance payments until the two together reached the all-source maximum of 80 per cent, even though the insurance benefits were fixed at only 70 per cent of pre-disability earnings. See: *Jones v. Confederation Life Insurance* (23 October 1992) (Nfld. S.C.T.D.), [Unreported].

59. A. Kyle and D. Thibeault, "Opposing Forces" (July-August 1991) 15 *Benefits Canada* 18 at 19.

As a result of these deductions, public plans end up as the primary payer while private insurers merely "top up" claimants' benefits. Insurers actively encourage claimants to apply for CPP disability benefits,⁶⁰ though they do not increase their income at all.⁶¹ Since many private plans pay no more than two-thirds of the claimant's previous earnings, while Workers' Compensation in Ontario, for instance, pays up to 90 percent, it is quite possible for an insurer to owe no money at all to disabled group members.

The well-known case of *Brooks v. Canada Safeway Ltd.*⁶² shows that insurers are not above designing plans so as to shift the total burden to public plans, even if the result is reduced benefits to group members. In *Brooks*, the employer's group plan provided short-term disability benefits, but excluded pregnant women during a seventeen-week period in which they would be entitled to (less generous) Unemployment Insurance maternity benefits. The Supreme Court held in a unanimous judgment that this constituted discrimination on the basis of sex under the Manitoba Human Rights Code and that the pregnant women were entitled to the private plan's benefits.

The private insurers' self-assigned role as second payer also allowed them to profit from inflation. As public benefits such as CPP disability and Workers' Compensation increased to keep up with inflation, they made up a steadily larger amount of the fixed total benefit guaranteed under private plans, so that the portion paid by private insurers steadily declined. The result was that as beneficiaries' real income decreased due to inflation, so the insurer's obligation to them also decreased both in real terms and absolutely.

The Association of Superintendents of Insurance of the Provinces of Canada became aware of this problem, but decided not to deal with it through any amendments to their Uniform Accident and Sickness Insurance Act, which is in force in slightly different forms in all common law provinces. Instead, they added a provision to their non-binding guidelines, effective January 1, 1978, that disability insurance benefits should "not be reduced because of a government sponsored plan or support program cost-of-living adjustment," except

60. The claimant admitted he was only before the Board at his insurer's insistence in *Minister of National Health and Welfare v. Brown* (1989), C.E.B. & P.G.R. 8579 (Can. Pen. App. Bd.).

61. According to one doctor, his widowed patient's successful application for CPP disability benefits (made at the insurer's suggestion) actually reduced her CPP survivor's benefits: D. C. Symington, "Mary, Mary and a Quite Contrary System" (Spring 1988) 19 *Rehabilitation Digest* 3 at 4.

62. [1989] 1 S.C.R. 1219.

where the private benefits were adjusted by at least the same amount.⁶³ There is some evidence that this provision has been largely followed in the industry,⁶⁴ but at best it ensures only an indexation of the portion of benefits paid by a public plan.

Representatives of the insurance industry have in any case indicated publicly that they welcome the erosion of benefits by inflation because it prevents "malingering." In 1977, Roland Nelson, a vice-president of Travelers Insurance speaking on behalf of the Canadian Association of Accident and Sickness Insurers, told a meeting of provincial Superintendents of Insurance:

"There is complete agreement within the industry that the problem of overinsurance is very real, i.e., when an individual has available disability benefits which in the aggregate are sufficient to induce him to go on claim and/or cause him to stay on claim longer than would normally be required in the circumstances. The problem must be addressed.

...

Companies attempt to avoid overinsurance through the application of tables showing the maximum amount of benefits they will issue to applicants with various earned incomes. These are made complicated by their efforts to reflect the impact of various government benefits. These practices, however, provide no protection against overinsurance created by the addition of new benefits or the increase of existing benefits subsequent to issue.

Companies have come to rely to some extent on the impact of inflation to ease the effects of overinsurance. In an inflationary economy, the income requirements of the insured will increase rapidly and eventually the overinsurance aspect of level benefit payments will tend to disappear. This control will disappear if the rate of inflation can be returned to an acceptable level."⁶⁵

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63. Association of Provincial Superintendents of Insurance, "Guidelines Governing Group Accident Insurance and Group Sickness Insurance," cited in G. N. Watson and B. R. Ouimet, "Elements of Group Insurance," in *CLU Textbook Library* (Don Mills: The Institute of Chartered Life Underwriters of Canada, 1984) at D-7.
64. A specimen contract in G. N. Watson and B. R. Ouimet, *Elements of Group Insurance*, 1989 ed. (Don Mills: Life Underwriters Association of Canada, 1989) at A-27 provides that income from the QPP or CPP disability benefits will be a direct offset from the amount of long term disability insurance payable, but "any increase in the disability benefit under the Quebec/Canada Pension plan because of an automatic adjustment in the cost of living index... is not considered income for the purpose of determining the amount payable."
65. Association of Superintendents of Insurance of the Province of Canada, *Minutes of the Proceedings of the Sixty-First Annual Conference* (Toronto: Office of the Secretary, 1978) at 123-24.

Obsessed as they are with the dangers "if overinsurance and voluntarily prolonged disability become prevalent," the insurers are therefore content to allow the incomes of the disabled to be eroded by inflation at a pace slowed only by the indexation of public schemes.

The public subsidization of private insurers reached new heights in 1987 when the federal government increased Canada Pension Plan disability benefits by \$152. At the time Parliament debated the change in 1986, concerns were raised that it would allow private insurers to reduce their payments. But the Minister of Health and Welfare, Jake Epp, said he had dealt with the problem through an arrangement with the Canadian Health and Life Insurance Association. Only a few months later, however, a government Member of Parliament complained in the House of Commons that a constituent employed by George Weston Ltd. had seen her disability benefits under a plan from London Life reduced by an amount equal to the CPP increase.⁶⁶

Epp insisted this was exceptional and that in "98 percent of all contracts" the increase had been passed on to beneficiaries. However, a spokesman for London Life reported that the reduction in benefits to Weston's employees was the result of a standard provision in disability insurance contracts. Said Jim Etherington: "We're the innocent party, we approached all our clients and asked what they would do. Weston said 'we'll stick to the contract.'"⁶⁷

Since most private disability insurance plans set a flat maximum level of benefits from all sources,⁶⁸ most contracts would have required a specific change to that amount in order to pass on the increase. Both the Guidelines from the Association of Provincial Superintendents of Insurance and an example of a standard contract in an insurance industry textbook forbid the offsetting only of cost-of-living adjustments to QPP or CPP disability benefits, not lump sum increases. It therefore seems likely many insurers simply cut benefits by the increase to CPP.⁶⁹ As London Life's spokesperson pointed out, the government could have dealt with the entire problem through legislation, rather than asking insurers to request changes to their clients' individual contracts.⁷⁰

66. "Parl-Disability" (31 March 1987) Canadian Press Newstex.

67. *Ibid.*

68. *Supra*, note 64 at A-27.

69. This is the conclusion of H. Beatty in "Comprehensive Disability Compensation in Ontario: Towards an Agenda," (1991) 7 *J. L. & Social Pol'y* 100 at 137.

70. *Supra*, note 66.

Epp later reported full compliance with his request, outside of a group of some 15 to 20 companies and unions (such as George Weston Ltd.) with self-insured plans, under which benefits were administered by an insurance company but guaranteed by the employer.⁷¹ More recently, however, officials at Health and Welfare Canada's Income Security Programs division have admitted that Epp did not take any steps to monitor the level of compliance with what was merely a voluntary policy of the Canadian Health and Life Insurance Association, nor did the CLHIA itself monitor compliance by its members.⁷²

VII. LEAVING WELL ENOUGH ALONE:

THE REGULATION OF DISABILITY INSURANCE

The fact that the Superintendents of Insurance offered no disagreement when a vice-president of Travelers Insurance expressed his pleasure that inflation eroded benefits (as cited above) shows the extent of their "regulatory capture" by the industry. After these remarks, the Quebec Superintendent, Jacques Roy, firmly agreed overinsurance represented a serious problem and suggested a "solution" would have to begin with the principle "that government programs should be first payers."⁷³

Assuring private insurers the status of secondary payers is consistent with a 1977 study of life insurance regulation in Canada, which concluded that the purpose of government regulation has always been to secure the solvency of insurers so they could accumulate policy-holders' savings and channel them

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71. S. Kerstetter, "Disability" (12 May 1987) Canadian Press Newstex. It is difficult to believe the problem stemmed from self-insured plans (under which benefits are administered by an insurance company but guaranteed by the employer) since a representative of insurance managers at 220 of Canada's 500 largest corporations reported in 1980 that all of their long-term plans were guaranteed by insurers and they self-insured only short-term disability benefits; Association of Superintendents of Insurance of the Provinces of Canada, *Minutes of the Proceedings of the Sixty-Third Annual Conference* (Toronto: Office of the Secretary, 1980) at 126.
 72. Letter from Monique Plante, Assistant Deputy Minister, Health and Welfare Canada to David Schulze, 12 January 1993. Plante commented that the CLHIA reported "very few, if any, complaints on this issue" which it felt "may be a strong indication that the policy in question was widely implemented." She continued: "It is interesting to note that Health and Welfare received very few complaints as well."
 73. *Supra.* note 65 at 125, 126. This view seems to be shared by the federal government, which announced plans to amend the *Canada Pension Plan Act* to allow benefits to be assigned directly to insurance companies, in order to solve their problems collecting from disabled workers: Monica Townson, "Your Money Q&A: How public service disability benefits integrate with CPP" (23 September 1992) *Financial Post* 18.

for long-term investments, "with little regard being paid to fair treatment of the consumers."⁷⁴

The same study was unable to find a single prosecution under the section of Ontario's *Insurance Act* prohibiting unfair and deceptive acts and practices, though cases of prohibited practices could be found in the law reports. At the time, the Superintendent of Insurance explained no action had been sufficiently serious to warrant a prosecution. Citing two cases in which the Superintendent had actually supported companies in cutting off benefits under accident and sickness policies, though the facts suggested the beneficiary had a good cause of action, the study concluded the Superintendent was simply not interested in exercising his powers.⁷⁵

When the Association of Superintendents of Insurance proposed amendments to *The Uniform Life and Accident Sickness Insurance Acts*, which would have required insurers to disclose more information to group plan beneficiaries, the companies mounted an effective lobby against the changes. The insurers' approach on this issue has been consistent: they are responsible for collecting employees' premiums, but not for ensuring they are properly informed about the plan. Over four years, they presented objection after objection, even to the point of claiming the heavy cost of the customized printing of information for each plan's beneficiaries would increase the cost of coverage.⁷⁶ The amendments eventually dwindled from a responsibility by the insurer to deliver detailed information on the plan to each group member to merely providing certificates to the employer in sufficient quantity for distribution.⁷⁷ A recent discussion paper by the Insurance Commission of Ontario continues this compliant approach by calling merely for a right to inspect the policy or to obtain a copy "on payment of reasonable fees."⁷⁸

74. G. Tumwine-Mukubwa, *A History of Life Insurance Regulation in Canada, 1868-1976* (LL.M. thesis, York University, 1977) at 164.

75. *Ibid.* at 152-54. In a 1986 interview, Manitoba's Superintendent of Insurance admitted he believed moral suasion was more effective than legal action in regulating the industry; James Fleming, *Merchants of Fear: An Investigation of Canada's Insurance Industry* (Markham: Penguin Books, 1986) at 382.

76. *Supra*, note 65 at 107.

77. Association of Superintendents of Insurance of the Provinces of Canada, *Minutes of Proceedings of the Sixtieth Annual Conference* (Toronto: Office of the Secretary, 1977) at 95; Blair Fraser, ed., *The Uniform Life and Accident & Sickness Insurance Acts*, rev. ed. (Toronto: Stone & Cox, 1983) at 48.

78. Report of the Insurance Legislation Review Project to the Ontario Insurance Commission, *Insuring for the Future: Modern Insurance Legislation for Ontario* (May 1991) at 145.

The final amendments to the *The Uniform Life and Accident & Sickness Insurance Acts* also left out a proposed provision that, when a plan was terminated without replacement, group members would be entitled to benefits until they were informed of this by the insurer. Industry representatives called it "unfair and improper to require the insurer to be held liable [for] responsibilities beyond their control," while forcing employers to provide proper information was "a government responsibility." The best solution, suggested Robert G. Mephram, a vice-president of London Life, was simply to assume beneficiaries were informed: "When salary cheques stop coming, an employee should surely be deemed to know that his group insurance benefits have also terminated." Once again these comments passed without objections from the Superintendents of Insurance.⁷⁹

Until recently, human rights commissions have been little better at regulating the industry. *Brooks v. Canada Safeway*⁸⁰ was an appeal of a decision by Manitoba's commission that a benefits plan excluding pregnant women from certain benefits did not constitute discrimination on the basis of sex. The Ontario Human Rights Commission reached settlements in two cases of discrimination by insurers whose group plans offered 24 months of benefits to those with physical disabilities but only 12 months of coverage to those with a mental disability. When it settled the first complaint against Confederation Life in 1990, the commission said the provision was "commonly used in the industry" and announced it would address the problem industry-wide. However, no action appears to have been taken by the time a similar complaint against Great-West Life was settled a year later and Chief Commissioner Catherine Frazee merely said she would write to insurers "urging" them to delete the exclusionary clause from their contracts.⁸¹

VIII. PERSPECTIVES FOR REFORM

This paper has presented evidence that private disability insurance is philosophically at odds with equitable income replacement, which alone should be reason enough to abolish it. It is also inevitably selective and therefore incapable of providing anything approaching universal insurance. As Terence Ison succinctly put it: "If it is right that what people want and need is income insurance that will provide for the duration of a disability, income at a level not

79. *Supra*, note 65 at 118.

80. *Supra*, note 62.

81. C. Lakshman, "Insurers told to end biased policies," *Financial Post* (7 November 1991) 3.

too far below the level of lost earnings, this type of insurance can only be made universally available through a social insurance system."⁸²

The problem is not to make the case for a public comprehensive disability insurance program. It has been recommended for Ontario in three separate reports in seven years: by the Legislative Assembly's Select Committee on Company Law in 1981, by Paul Weiler in his inquiry into Workers' Compensation in 1983, and by the Social Assistance Review Committee in 1988.⁸³ It was also endorsed federally by the House of Commons Special Committee on the Disabled and the Handicapped in 1981, for Manitoba in a government white paper in 1977 and for Saskatchewan by a special committee in 1976.⁸⁴

Unfortunately, action on these reports has been noticeable by its absence, and the report of a joint federal-provincial committee study of a comprehensive disability protection program remains unpublished, though it apparently recommended only minor reforms.⁸⁵

The current New Democratic Party government in Ontario struck an inter-ministerial task force on universal disability insurance in 1991, which had not reported at the time of this writing, and Workers' Compensation Board chair Odoardo Di Santo has publicly called for the creation of such a program to supplement benefits from the Board.⁸⁶ However, given the Ontario government's decision not to take over what would be an essential element in a comprehensive disability program—automobile insurance—a review of possibilities for short-term reform still appears in order.

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82. T. G. Ison, *Human Disability and Personal Income* (Kingston: Industrial Relations Centre, 1978) at 5.
83. Ontario, Select Committee on Company Law, *The Insurance Industry; Fifth Report on Accident and Sickness Insurance* (Toronto: Legislative Assembly, 1981); Paul C. Weiler, *Protecting the Worker from Disability: Challenges for the Eighties* (Toronto: Ministry of Labour, 1983); Ontario, Social Assistance Review Committee, *Transitions* (Toronto: Ministry of Community and Social Services, 1988). The case has also been made more recently by H. Beatty in "Comprehensive Disability Compensation in Ontario: Towards an Agenda," (1991) 7 *J. L. & Social Pol'y* 100.
84. Canada, Special Committee on the Disabled and the Handicapped, *Obstacles: Third Report* (Ottawa: House of Commons, 1981) at 53; Manitoba, *Accident and Sickness Compensation in Manitoba: A Government White Paper* (Winnipeg: Queen's Printer, 1977); Saskatchewan, *Report of the Sickness and Accident Insurance Committee*, ([Regina]: [Department of Labour?], 1976).
85. L. Muszynski, "An idea whose time has come: Universal disability insurance should replace an irrational and unfair system," (Spring 1989) 13 *Perception* 55 at 56.
86. B. Reno, "Reforming WCB" (April 1993) *The New Ontario Democrat* 22.

On the surface, the Insurance Commission of Ontario appears to have powers wide-ranging enough to change the industry's way of doing business. The *Insurance Act's* prohibition on unfair and deceptive acts and practices includes not just the failure to respect provisions of the Act and a number of specific practices, but also "any conduct resulting in unreasonable delay or resistance to the fair adjustment and settlement of claims."⁸⁷ The Superintendent (the Commission's chief administrative officer) may investigate such practices and order any person engaging in them to cease, to leave the business of insurance, or to perform acts she judges necessary to remedy the situation.

However, even this part of the *Act* is weighted in favour of insurers: the Superintendent's power to investigate and make orders is entirely discretionary, so that beneficiaries of insurance have no statutory right to complain nor to demand a hearing. By contrast, those engaged in unfair practices against whom the Superintendent is contemplating an order have a right to notice, to a hearing before her, to an appeal to the Commissioner, and to a stay of any decision pending judicial review.⁸⁸ Given the insurance industry's willingness to fund long-term litigation, prosecutions do not seem a promising way to change the treatment of disabled claimants.

A far simpler means would be to provide better mechanisms for complaints and appeal. This could in fact be implemented fairly easily in Ontario since the *Insurance Act* allows the Lieutenant Governor-in-Council to make regulations "governing group insurance contracts or schemes, or any class thereof including prescribing and regulating their terms and conditions, qualifications for membership in groups and regulating the marketing of group insurance contracts or schemes."⁸⁹

Currently, the regulation of group insurance is an afterthought to *The Uniform Accident Sickness Insurance Act*, produced by the Association of Superintendents of Insurance of the Provinces of Canada: provisions to regulate it were not even introduced until 1970.⁹⁰ The result has been that through statutory

87. R.S.O. 1990, c.I.8, s.438(i).

88. *Ibid.* ss. 438, 439, 441, 18, 20.

89. *Ibid.* s.121.

90. B. Fraser, ed., *The Uniform Life and Accident & Sickness Insurance Acts*, rev. ed. (Toronto: Stone & Cox, 1983) at 43. The delay is partly a reflection of the predominance of life insurance concerns in accident and sickness insurance regulation: while group plans have outnumbered individual health policies in Canada since at least 1950, group life insurance policy ownership did not begin to dominate the market until the early 1970s; Canadian Life and Health Insurance Association, *Canadian Life and Health Insurance Facts* (Toronto, 1991) at 14, 48.

conditions, beneficiaries of individual policies receive somewhat better protection than those in group plans: failure to give notice of claim within the prescribed time (90 days) does not invalidate the claim if it is provided "as soon as reasonably possible"; the insurer must provide forms for proof of claim within 15 days of notice and pay initial benefits for loss of time within 30 days.⁹¹ There is no reason why these should not be immediately extended to group policies.

A number of conditions imposed on automobile insurance policies as part of the no-fault benefits, which are provided to those who sustain "physical, psychological or mental injury as a result of an accident", could also usefully be imported into the regulation of accident and sickness insurance. It is difficult to see why the beneficiaries of disability insurance currently receive less generous treatment from the law than those injured in automobile accidents, even though they too are usually indemnified without regard to fault.

Under the No-Fault Benefits Schedule⁹², automobile insurers may deduct benefits under other plans from their payments, but they must pay full benefits until the claimant actually receives them; in addition, neither social assistance nor Workers' Compensation benefits may be deducted from them under the Act.⁹³ This effectively discourages tardy claims processing and the use of social assistance as a public subsidy for delays. In addition, the Schedule provides specific time limits for making payments and penalizes delays at the rate of two percent interest per month, payable to the claimant, providing a clear financial incentive for proper claims processing.⁹⁴

The Schedule also explicitly states that a failure to give notice of a claim within the set time limits does not invalidate it, if the person "has a reasonable excuse" and files within two years of the accident.⁹⁵ By contrast, the *Insurance Act* imposes a one-year limitation period as a statutory provision in individual disability insurance policies⁹⁶ and, while the *Act* is silent on group policies, the same provision is commonly added by insurers.

91. R.S.O. 1990, c. I.8, s. 300.

92. *No-Fault Benefit Schedule*, O. Reg 273/90.

93. *Supra*, note 12, s.267.

94. O. Reg 273/90, s.24.

95. *Ibid.* s.22(2).

96. R.S.O. 1990, c.I.8, s.300, Statutory Conditions No. 12, but under s.301(b) the period may be lengthened at the Court's discretion. This provision is adopted from the Uniform Act and is found in all common law jurisdictions except the Yukon and Northwest Territories, where the period is two years.

Limitation periods do not actually bar claims completely. Instead, the courts have held:

“Causes of action for the recovery of ongoing payments, such as income-replacement benefits under no-fault auto insurance or accident and sickness insurance, continually renew themselves each time an instalment becomes payable because the insurer is under a continuing liability for each succeeding benefit.”⁹⁷

The limitation is therefore only on the period in the past for which benefits can be claimed.

But the practical effect of limitation periods is to reward insurance companies for delay when dealing with terminated claims: after 12 months, every day a former claimant spends pursuing any process other than legal action is a day of benefits the insurer will not have to pay. There is no reason why a normal limitation period of six years should not apply to disability insurance policies, as it does to most other contracts. If anything, the depression that can characterize disability and is often exacerbated by the termination of benefits, argues for a longer limitation period.

The 1990 amendments to the *Insurance Act* also made a special dispute-resolution mechanism available to beneficiaries of the automobile no-fault provisions. Either the insured person or the insurer may refer any matter regarding entitlement to no-fault benefits to a mediator, on application to the Insurance Commission. If mediation fails, the insured person may either bring a court proceeding or ask the Commission to appoint an arbitrator, whose decision can be further appealed to the Director of Arbitrations. Pending the outcome of either proceeding, the insurer must pay its last offer of settlement to the beneficiary.⁹⁸

While it will be necessary to study the experience of automobile insurance claimants under dispute resolution, it is difficult to imagine how it could be less effective than traditional litigation for accident and sickness insurance. Currently, the courts are the scene of repeated findings of fact as to states of disability, in which questions of law are usually of minor importance. Any danger which might exist of mediators encouraging settlements for less than the full claim is probably no greater than that posed by average legal representation.

97. C. Brown and J. Menezes, *Insurance Law in Canada* (Toronto: Carswell, 1991) at 240. See, for instance, *Zappone v. Mutual of Omaha Insurance Co.*, [1983] I.L.R. 1-1708 (Ont. S.C.).

98. *Supra*, note 12, ss.279-284.

With mediation, pre-trial negotiations between claimants and insurers could take place within a formal structure and with a written record, but without the initial expense of legal counsel. The obligation of the insurer to pay its last settlement offer (assuming there is one) pending litigation or arbitration might actually provide the necessary financial resources for claimants determined to proceed. More importantly, the provision means claimants may continue their financial lives in the interim and would help to remove the insurance companies' "veto" on rehabilitation that Justice Coulter Osborne decried in the case of automobile accident disability benefits.⁹⁹

A similar change would be to provide that all disability policies are incorporated by reference into any collective agreement which provides that workers shall receive their benefits. Currently, a unionized worker can grieve the right to benefits only when the plan itself is part of her collective agreement. If the employer's obligation is simply to provide insurance coverage, then employees must pursue individual claims against the insurer in court.¹⁰⁰ Making all unionized workers' claims subject to the jurisdiction of grievance arbitrators would give them inexpensive access to a less formal process. Such a change would, of course, have to provide that, in case of any disagreement, the provisions of the collective agreement would take precedence over those of the policy so as to provide workers with exactly the coverage for which they bargained.¹⁰¹

Unions should also be assigned a continuing obligation to represent claimants in respect to the plan, even after they have ceased being dues-paying members because of their disability, a responsibility which many currently avoid. At the same time, given the life-long importance to individual recipients of the right to benefits created by collective agreement, it might be advisable to make grievance arbitration a non-exclusive procedure in order also to provide unionized disabled workers with access to an individual mediation process and to the courts.

99. *Supra*, note 11 at 163.

100. See for instance, *Re Molson's Brewery (Ont.) Ltd. and B.F.C.S.D., Loc. 304* (1978), 17 L.A.C. (2d) 354 (Ont. Arb. Bd.).

101. If this change were implemented through the *Insurance Act*, rather than labour relations legislation, it would be a statute of general application which would also cover federally-regulated employees.

IX. AFTERWORD

Whatever minor advances may be possible through improved regulation, advocates for disabled workers should be aware of the need for constant vigilance when dealing with private insurers. The evidence suggests they cannot be relied upon to conduct themselves to the advantage of their claimants.

To give one more example: in a 1990 article in *Canadian Underwriter*, two accountants who work with disability insurance companies warned that “in many cases, files receive a cursory review by an inadequately trained underwriter” and “one of the most common causes of error related to this type of financial underwriting is miscalculation of earned income.”¹⁰² Their concern was not undercompensated beneficiaries, but rather that these practices “can lead to over-insuring, inaccurate applications and unnecessarily high payouts.”¹⁰³ Disabled workers will always have to be wary of an industry more anxious to guard against overcompensated beneficiaries than to ensuring that its own defects do not lead to underinsurance and insufficient payments to the claimants it is meant to support.

102. Paul Dunnett and Stewart Katz, “Growing pains afflict disability insurance” (September 1990) 57 *Cdn. Underwriter* 65.

103. *Ibid.* 66.