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Can A Special Award Be Found When I Do Nothing Wrong Procedurally?

The determination of what constitutes a special award is somewhat akin to the controversy over whether a provocative picture is a piece of art or pornography. The distinction between the two is often blurred, leaving many to rely on the old scientific formula of telling the difference by stating: "I will know it when I see it". This rough and ready guide to assess whether a picture should hang in a museum, or under a teenager's mattress, is not that far off from the law regarding when an insurer's conduct constitutes a special award.

It goes without saying that there are obvious cases that cry-out for a special award such as if an insurer does not follow the advice of its own doctors or simply neglects to respond to a claimant. The more unsettled question, however, is when will an insurer be found obligated to pay a special award when it follows all proper procedures by listening to the advice of its own medical assessors?

The Basics

The decisions of *Carr v. TD General Insurance Company* (July 23, 2010) and Sinnapu v. Economical Mutual Insurance Company (July 30, 2010) are two prime examples which offer contrasting decisions as to when a special award will be found. It is relevant to note that these two decisions were released one week apart, were argued by the same claimant counsel, and the basis for the argument for a special award was essentially the same. In one case a special award was found and the other it was not.

Subsection 282(1) of the *Insurance Act* sets out the basis for a special award:

If the arbitrator finds that an insurer has *unreasonably withheld or delayed payments*, the arbitrator, in addition to awarding the benefits and interest to which an insured person is entitled under the Statutory Accident Benefits Schedule, shall award a lump sum of up to 50 per cent of the amount of which the person was entitled at the time of the award together with interest on all amounts when owing to the insured (including unpaid interest) at the rate of 2 per cent per month, compounded monthly, from the time the benefits first became payable under the Schedule *(emphasis added)*.

Accordingly, the insurer need not have acted maliciously, but simply acted unreasonably or with delay. Insurance law has required that the insurer act with utmost good faith in its dealing with the insured and must make decisions based on all the available evidence. The question then becomes, does an insurer acted unreasonably if it chooses to follow the recommendations of its own insurer examination doctors.

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Your comments are appreciated and if there are any commercial or insurance related topics that you would be interested in reading about, please feel free to email us and we will certainly explore the possibility of writing an article. Contact: defender@beardwinter.com

No Special Award Found

In *Carr v. TD General Insurance Company*, the claimant had obtained its own assessors as did the insurer including that of a prominent orthopaedic surgeon. The issues in dispute were entitlement to income replacement benefits based on the pre /post 104 test and medical benefits. In coming to a decision, the Arbitrator chose to accept the evidence of the claimant and not that of the insurer orthopaedic surgeon. In particular, the Arbitrator critiqued the orthopaedic surgeon (who testified at the Arbitration) for having incomplete information about the claimant, for having a "different and unconventional theory regarding pain", and various other matters that led the Arbitrator to conclude that, "I placed little weight on the reports and testimony" of the doctor. The claimant won 100% of the benefits in dispute.

When determining the issue of a special award, there was no issue regarding the procedural handling of the claim. The Arbitrator specifically found as follows:

"While I find that there were serious flaws in the assessments and medical reports relied on by the insurer to makes it decisions about Mr. Carr's entitlement to benefits, I am not persuaded that the insurer met the standard of unreasonably withholding or delaying payments to Mr. Carr. It was not unreasonable of the insurer to withhold the payment of benefits to Mr. Carr based on deference to the medical opinions of its own assessors. However, it is to be hoped that insurers will aspire to a higher standard resulting in a more careful review of their medical reports, comparing and contrasting them with those of their insured, so as to guarantee the utmost fairness in their handling of claims".

As such, the Arbitrator not only accepted the evidence of the claimant / claimant assessors over that of the insurer, but found that there were serious flaws in the insurer assessments. Despite these serious flaws, the Arbitrator found that the actions of the insurer in relying on it own assessments' was not unreasonable in these circumstances. In her closing comments, however, the Arbitrator did somewhat ominously comment that it is hoped that an insurer will, "aspire to a higher standard" and review all the assessments to guarantee "utmost fairness".

Accordingly, this case serves as a precedent that an insurer is acting in good faith if it relies on its own medical assessments. An insurer may lose, but it will not be required to pay a special award.

Special Award Found

In *Sinnapu v. Economical Mutual Insurance Company*, the Arbitrator came to the opposite conclusion. In this case the claimant was seeking payment of interim income replacement benefits based on the post-104 test for entitlement and each side obtained medical reports to support their case. Similarly, the insurer relied on the report of a section 42 orthopaedic surgeon who concluded that the claimant did not meet the test for disability. This was in contrast to the claimant's own assessments. The Arbitrator strongly criticized the evidence of the insurer expert commenting that he "was either slipshod or was tailoring his report to suit was he perceived as Economical's needs or his own prejudices". Suffice to say, the Arbitrator rejected the conclusions reached by this assessor.

The Arbitrator found that in accepting the conclusions of the section 42 assessor in the face of contradictory evidence from other experts that Economical had acted unreasonably. The Arbitrator stated that the insurer had "made no apparent attempt to reconcile conflicting reports, or weigh the value of [the doctor's] opinion in an area that was clearly outside his claimed expertise."

Importantly, the Arbitrator accepted that the insurer had complied with its procedural requirements under the Schedule. The insurer obtained a report that supported its position and relied upon it. There was nothing procedurally wrong with doing so. However, from a substantive standpoint, the Arbitrator found that the insurer ought to have accepted the assessment of the claimant doctors over that of its own assessor. On account of this substantive failing the Arbitrator concluded that a special award was warranted with a rather high quantification of 40% of the benefits and interest outstanding.

Conclusion

The test undertaken to determine an entitlement to a special award is whether the insurer had acted unreasonably. In both of these cases, the insurer relied on the assessments of orthopaedic surgeons in making a determination as to whether to pay benefits or not. Some may argue that it is reasonable for an adjuster to defer to the expertise of an insurer examiner doctor in making such a decision. This is not to say that that this doctor is correct, but that this was a reasonable action by the adjuster. Although an insurer is required to act in good faith, this does not mean that it is must choose to accept the claimant's assessment over that of the section 42 assessment when there is a dispute.

There is no set guideline as to when a special award will be found

in these circumstances. The facts of the case will dictate how egregious the error by the assessor, and / or how significant the Arbitrator considers this error when deciding if a special award is in order.

Insurers should not review their files with a pessimistic eye towards searching for a special award around each corner. If we start assessing files scared, then surely bankruptcy will not be far away. Yet, if it is clear that the insurer's position is extremely weak then perhaps damage control by way of a settlement for the value of the benefits is the best option. Remember, although both a claimant and an insurer have a duty of good faith to act in relation to one another; a special award can only be awarded against an insurer. The lesson to be learned is that if a picture is indeed pornographic, hide it under the bed.

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