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INTERPRETATION OF "NEW GENERATION" CONTRACTS – A CASE STUDY

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1. In the first part of this presentation we looked at the wording usually found in traditional disability policies and the variations on a theme which occur in such wording, and how the principles of interpretation are applied.

2. I would now like to look at the interpretive issues which can be thrown up when one is dealing with one of the so-called "new generation" or "new era" disability products. The difference with such a product lies in the departure from the traditional approach which is based on an insured's ability to perform a specific or related (similar) occupation, so as to be income-earning. The new product ignores earning capacity, which can be seen as subjective, but rather relates the benefit to the actual medical condition and degree of impairment. A lump sum "disability benefit" is payable not if an impairment affects one's ability to perform a specific occupation, as in the classic disability benefit, but according to a system of strict medical criteria, characteristically described in the marketing as "objective and fair" – this is a strong selling point.

3. Drafting contracts for a new product is obviously treading on untested ground, and the bugs only really become apparent when the contract is test-driven in real life. The case study I shall deal with here illustrates again how the wording in policy documents can give rise to disputes, and demonstrates how, in this specific dispute, the Ombudsman's office would go about interpreting the contract so as to determine the rights of the respective parties.

4. Let me set out first the salient facts of the case. I'll have to go into a bit of medical detail, the relevance of which will become clear later. The complainant, let's call him Mr C, was a self-employed mechanic. In 2003 he found himself in Groote Schuur hospital twice after having seizures, once in January, and again in December the same year. He was diagnosed as having a prothombotic tendency (tendency for blood to clot), manifesting clinically as a deep vein thrombosis (in his legs) with severe bilateral pulmonary embolism (bits of clot in the legs break off and lodge in the lungs), in January 2003 and as a sagittal sinus thrombosis (clot in the brain) with bilateral cerebral venous infarcts (parts of the brain denied blood supply and die) and generalised seizures in December 2003.

5. The neurologist at Groote Schuur Hospital who treated him noted that he would have to take Warfarin, a blood-thinning drug to prevent clotting, for life. He was also on Sodium Valproate, a cerebral depressant, for his seizures. Formal neuropsychological testing revealed deficits in executive (high-level) functioning – he was noted to be unable to engage in abstract thought, showed perseveration and displayed deficits in attention and working memory. The neurologist's view was that the complainant was no longer capable of engaging in his former occupation as a mechanic. In addition to his executive dysfunction, the neurologist stated his view that "the combination of using Warfarin in a patient with seizures is fraught with difficulty, and then to additionally expose such a patient to a workshop environment with dangerous moving machinery and expect him to continue to work is an irresponsible and dangerous practice. Hence, our recommendation that he be classified as disabled, and be boarded from work." It appears that the complainant would run the risk of severe bleeding if injured while on Warfarin anticoagulation therapy, in that a relatively minor laceration could result in hospitalisation.

6. Mr C submits a claim to his insurer for the capital disability benefit, which his policy schedule tells him is worth R200 000. The claim is turned down. In a letter to Mr C the insurer sets out the criteria for capital disability under the *nervous system*, which is where such ailments as seizures would fall. (I'll come back to these criteria shortly.) The insurer explains that "We do have sympathy with your condition but unfortunately your condition does not **meet the above-mentioned criteria under the Nervous System benefit**."

7. So much for the background. Now let's look at the policy, and the provisions which apply to the complainant. (I have added my emphasis in italics.)

In the policy, which is written in nice easy to understand English, not alienating legalese, there is a heading "What life-changing events am I covered for?" A "life-changing event" is defined as:

> "An illness or *disability so severe that it affects your ability to earn an income, and threatens to lower your standard of living*".

Certainly the insured would get the impression here that he would get a payout if he is so impaired that he cannot earn a living – the kind of disability cover that, ideally, one would like to have.

It continues:

> "If all your premium payments are up to date, [the insurer] will compensate you for the occurrence of life-changing events or benefits indicated on your Policy Schedule".

8. The policy schedule indicates that the Capital Disability Benefit is the applicable benefit. Turn to the section in the policy headed "Capital Disability Benefit", and we read that

> "This benefit pays a capital amount in the event of you being medically impaired *and hence unable to work*.
>
> …
>
> Medical impairments that qualify you for Capital Disability Benefit payments are evaluated on how severely your disability affects you. This benefit rates severity in only 2 categories:
>
> Category A – Pays out 100% of the benefit if your disability satisfies the criteria for Category A. These criteria are *designed to establish whether your disability prevents you from working at all*.
>
> Category B – Pays out 50% of the benefit if your disability satisfies the criteria for Category B. These criteria are *designed to establish whether you are able to still partially fulfil your job*.
>
> Please refer to Appendix 2 for details on how the criteria used to establish severity ratings will determine into which category you fall."

9. There are different sections for each biological system of the body: cardio-vascular system, digestive system, mental and behavioural disorders, etc. Let's zoom in to the "nervous system" section, the impairment category into which the complainant's condition has been classified. It includes illnesses that affect the brain, nerves or muscles, the ability to speak, see, hear, walk, move or control basic bodily functions. Here we find the following statement:

> "Most of these illnesses can be assessed through strict screening tests e.g. sight or hearing tests, but *others are more subjective*. In the latter case, [the insurer] again uses the activities of daily living *to assess incapacity to work*, for example, the inability to communicate, loss of memory, impaired locomotion, etc."

10. In the Appendix we get to the nitty gritty. Remember Category A gives you a 100% benefit and Category B gives you a 50% benefit. This is the impairment you must have to qualify:

> **Category A**
>
> Total aphasia or able to perform ≤2 basic activities of daily living or persistent vegetative state or complete destruction of both optic nerves or persistent disabling hemiplegia or severe bilateral facial paralysis or loss of bowel and

> bladder function or <20/200 Snellen rating bilaterally or total loss of hearing bilaterally
>
> **Category B**
> Inability to comprehend or communicate language symbols or 85% speech impairment or able to perform ≤4 basic activities of daily living or complete destruction of one optic nerve or persistent disabling monoplegia or <20/125 Snellen rating bilaterally or >75% binaural hearing impairment.

11. The complainant did not meet the requirements of any of these strict screening tests. But the insurer repudiated the claim specifically on the basis that the neurologist had recorded a score of 5/6 on the Activities of Daily Living score sheet.

12. Let's take a look at this score sheet, also to be found in the Appendix. We are told in the policy that the ADL Score Sheet

> "is an internationally used scoring system that is used to assess the functional ability of a person in total, that is, it takes into account physical, social and interactive abilities of a person. [The insurer] uses the ADL's to assess functioning when objective criteria are insufficient, for example, in the assessment of strokes, neurological diseases, psychiatric diseases and diseases where the symptoms and signs are not easily definable."

The Score Sheet tests activities in six basic activity categories: Self care, Communication; Physical activity; Sensory function; Hand functions; and Advanced functions (which includes social interaction, understanding of concepts, memory, problem solving, stress adaptation, etc.)

13. The neurologist had filled in this score sheet and indicated that the complainant could perform all the activities under the first five categories. However in the last category, "Advanced activities", he scored the complainant as "poor" or "cannot" in almost every case, specifically memory, problem solving and stress adaptation. Thus the rating for this category was a failure, resulting in the score of 5/6 on the overall scale - in line with the neurologist's assessment of the complainant's executive dysfunction in his report. But according to the "Nervous system" criteria

the complainant was not unable to perform ≤ 4 basic activities, so he did not qualify for the benefit.

14. The question of course arises: if your memory is shot, and your understanding of ideas or ability to solve problems is poor or deficient, can you work? As someone in our office pointed out, as a matter of actual fact even a baboon can perform the first five activities – baboons groom and feed themselves, communicate with others, stand, sit, walk, kneel and so on, hear, see, smell and so on, grasp and hold with their hands. But a baboon cannot work!

15. So – what to do with Mr C? He may not meet the criteria but it would appear that practically, viewed objectively, he is unable to work.

16. The Ombudsman's office scrutinised the policy and commented that, reading the policy as a whole, it need not necessarily be interpreted as restrictively as the insurer had done. There was wording in the policy reminiscent of a classic disability policy, and provisions which, properly construed, meant that greater flexibility needed to be applied. The facts of this case provided an interesting example of where this would be so.

17. The Ombudsman's office pointed out to the insurer that, in interpreting the contract **to determine the common, or constructive, intention of the parties**, and **having regard to the contract as a whole**, one needs to reconcile the policy provision, for example, that

> "this benefit pays a capital amount in the event of you being medically impaired and hence unable to work",

with an exclusion simply on the basis of medical screening tests that do not specifically measure an ability to work.

18. The quoted statement indicates the nature and purpose of the contract: to provide cover if you are medically impaired and unable to work. The link between the criteria and the purpose are in fact explicitly acknowledged in the policy document, which states that

> (in the case of Category A) "these criteria are designed to establish whether your disability prevents you from working at all" or (in the case of Category B) "these criteria are designed to establish whether you are able to still partially fufill your job".

The Ombudsman's office suggested to the insurer that the criteria should be seen, in the context of the contract as a whole, as being guidelines to gauge whether an insured is able to work. The criteria should not therefore be applied mechanistically but to help the insurer to form an opinion as to the claimant's ability to work, the insurer retaining a discretion to override the strict application of the criteria in order to give effect to the policy provision that the benefit is payable if you are "medically impaired and hence unable to work", if indeed it is clear that the person cannot work.

19. On this interpretation, the complainant in this case, could well be found to meet the requirement for being paid a disability benefit, in that, on all the evidence, he is "medically impaired and hence unable to work". In fact it is arguable that his "disability prevents him from working at all" and that he should be paid the 100% capital disability benefit available under Category A.

20. On another tack, if one accepts the medical evidence from the treating neurologist that the complainant in this case actually is not capable of working, even though his impairments do not fall below the line of the criteria, could one argue that the criteria are unfair? More medical evidence would be needed to make this finding.

It should perhaps be pointed out that in a more recent, updated policy document now in use, two new alternatives have been introduced into the Nervous System criteria under Category B: “short term memory loss” and “moderate cognitive impairment”. (Under such policy wording the complainant would presumably have qualified.) This would seem to indicate an appreciation by the insurer itself that the criteria in the earlier policy document may not be adequate in that they exclude deserving cases.

21. The Activities for Daily Living score sheet is the insurer’s answer to the problem that objective criteria are sometimes insufficient. However, even this tool cannot assess capability to work if used in isolation or applied mechanistically. The complainant’s case provides a good example of someone who is fully functional in most respects allowed for on the score sheet (5 out of the 6 categories), but who utterly fails the 6th category (Advanced Activities), which happens to contain most of the abilities one would immediately recognise as being necessary to enable one to work as a mechanic: social interaction, understanding concepts, memory, problem solving. Again this would suggest that the stated criteria need to be applied with discretion.

22. What happened in the end with this case? We put our interpretation of the contract to the insurer and the insurer responded to our input by conceding that blind reliance on the Activities of Daily Living tool might have led to an unsatisfactory result. They suggested that a 50% benefit be paid immediately, and indicated that they would consider payment of the remaining 50% after the complainant had had a further full neuropsychological assessment to determine whether his cognitive impairment was moderate or severe. We accepted the reasonableness of this stance.