

PREPARING THE ACCIDENT BENEFITS FILE FOR A CASH OUT

Getting it Ready and Getting it Settled

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For many lawyers, handling an accident benefits claim is a daunting proposition – a mountain of paperwork, an extremely complicated statutory regime and clients who are likely to call weekly, if not daily. Cashing out the claim is seen as the light at the end of the tunnel. The client can get some much-needed money in his or her pocket, the insurance company will get off of everyone's back, and the lawyer can get paid for all of the hard work and money that he or she has invested into the file.

Knowing how, and when, to properly cash out a claim for accident benefits is both an art and a science. This paper will focus on some of the important aspects of cashing out an accident benefits ("AB") claim that counsel should consider before advising their client to sign on the dotted line. However, as with most facets of the law, there is no single correct approach that will work in every case. Counsel should be flexible, and creative, in order to craft the best possible settlement for their client given the unique facts and personalities involved in the particular claim.

To cash out or not to cash out? That is the question

Just about every AB claim is capable of being settled. Insurers like to settle claims and close files, despite certain public statements to the contrary. However, that does not mean that every case is ripe for settlement. The key is try to enter into settlement negotiations at a time that best suits the interests of the client, at a time when the lawyer is satisfied that the claim is ready for settlement. A number of factors go into this determination. The following are a few of the common issues that arise in this context.

How long ago was the accident?

The "Settlement Regulation" (ss. 9.1 and 9.2 of Ontario Regulation 664) was amended in 2003 as a part of the Bill 198 changes. The amendments effectively preclude settlement of an AB claim within one year from the date of the accident. If the case is otherwise ripe for settlement, or if the client is instructing you to explore settlement with the insurer, there are ways around this restriction.

It is important to note that there is not a true prohibition on settlements within one year from the date of the accident. The Settlement Regulation provides only that a prohibition on the insured's rights to mediate, litigate, arbitrate, appeal or apply to vary an order under sections 280-284 of the *Insurance Act* is void if the settlement takes place within one year from the date of the accident (s. 9.1(10)(b)). If the insurer doesn't raise the one-year issue, there is no practical reason from the insured's perspective to not enter into negotiations. Quite the opposite; the insured will likely be able to avoid the settlement if it turns out later to be inadequate, leaving your client with the best of both worlds; a settlement and a potentially open claim. Given the uncertainty

that an insurer will have to face if an AB claim is settled within that first year, it is unlikely that any insurer will agree to do so. However, you never know until you ask.

The effective prohibition on settlement within the first year has three exceptions - if examinations for discovery have commenced in a lawsuit, a pre-hearing conference has been completed in a FSCO arbitration proceeding, or an arbitration agreement under the *Arbitration Act, 1991* has been entered into, the parties may conclude a settlement within the first year from the date of the accident (s. 9.1 (11)). These exceptions create a method by which interested parties can get around the one-year restriction. When one examines the exceptions, they seem to have one thing in common - lawyers. While an accident victim does not have to retain a lawyer to commence a lawsuit or arbitration, it is very likely that they will at least contact a lawyer before taking such steps. It therefore appears that the exceptions were created to ensure that accident victims trying to enter into early settlements with insurers obtain advice from counsel. It would have been simpler, and less expensive than forcing parties to commence litigation or arbitration proceedings, to permit lawyers to negotiate AB settlements within one year from an accident. This would provide the protection for accident victims that the government was obviously trying to create, while also providing the flexibility to settle a claim at a time that both parties agree is appropriate. In any event, the Settlement Regulation does create a practical barrier to settlement that must be kept in mind.

Have the injuries plateaued?

Medicine is far from an exact science. No one can ever predict with certainty what an injured person will experience, or what the medical and rehabilitation needs will be, for the balance of

his or her life. However, at some point in time following an injury the medical community can begin to speak about reasonable probabilities. Until your client's injuries have reached the point where the medical community can opine, within reason, about what the future may hold, it is often too early to consider lumping out. Generally speaking, the more serious the injury, the longer that it will take to reach a plateau.

Is your client a person under a disability?

Lumping out a claim for a minor or a person who is mentally incompetent can be challenging and time consuming. In addition to the usual steps that one must take before negotiating a claim, the settlement for a person under a disability must be approved by a Judge pursuant to Rule 7.08(3). This approval will likely require the agreement of a Guardian and often a very detailed Management Plan under which the funds will be invested and distributed. If there is no one appropriate to act as a Guardian, the Public Guardian and Trustee or The Office of the Children's Lawyer will get involved in the case. In our experience, this is something that counsel should try to avoid, as significant delay can result from involving these government bodies. Family members, either alone or jointly with a trust company, are often the most appropriate guardians of an incompetent person's assets. These issues must be considered before the negotiations commence to ensure that an appropriate Guardian is in place to provide instructions and to manage any money that will flow from the settlement.

Is there a tort action?

There can be considerable overlap between the tort and AB claim. Most significantly, the tortfeasor may be entitled to a credit for statutory accident benefits that have been received by, **or that were available to**, the injured person (*Insurance Act*, ss. 267.8(1), (4) and (6)). This provides the tortfeasor with the ability to argue that the injured person settled his or her AB claim for an amount less than what was reasonably available to them. If successful, this argument would give the tortfeasor credit for benefits that your client never received, potentially reducing the tort award quite significantly. Arguments in this respect arose more frequently under O.M.P.P. claims, but fortunately the scope of the argument has been somewhat limited by Bill 59 and Bill 198. The combination of subsections 267.8(21) and (22) of the *Insurance Act* mean that, as long as an injured person has made an application for a benefit that was denied by their insurer, the claim can be settled as long as it is not done in "bad faith". The same argument can also be raised when there has been no denial of benefits, so counsel must be very careful when cashing out a claim that is still being paid by the AB insurer. The breakdown of the settlement as between the various types of benefits must be reasonable and pass the "smell test", lest a skeptical Judge get the sense that the insured was trying to allocate the settlement solely in their best interest, and to the detriment of the tort defendant. In any event, the client should be informed, in writing, of the risks associated with settling an AB claim before disposition of the tort action.

Cashing it out: What's it worth?

Based on your experience, you have decided that your client's claim is ready for settlement. How much is it worth? In most cases, this question is not answered by sitting down with the medical reports and your calculator. Three main areas should be considered before turning on your calculator.

Read the *Schedule*

We have had four different AB schemes in Ontario since 1990, contained in four different *Statutory Accident Benefits Schedules*. The *Schedules* have also been tinkered with from time to time, creating even more confusion as to the rules that apply to a particular claim. There are major differences between the systems that will be obvious after a brief review of the different *Schedules*. There are also numerous subtle differences between the *Schedules* that even experienced counsel find difficult to keep straight. Before taking any other steps, read the *Schedule* relevant to your case to make sure that you are covering all of the types of benefits potentially available to your client, both with respect to past benefits that ought to have been paid as well as future entitlements. Then, research the law that may affect your client's claims, both arbitral and judicial, as the law in this area is in an almost constant state of flux. A collateral benefit that was not deductible from your client's accident benefits a few months ago might be deductible today. Claims that were routinely denied for care provided by family members while an injured person was in hospital may have to be paid by an insurer today. Keep abreast of the law by reading everything that you can; the Ontario Reports, the various OTLA sources

including the chat line, the lawyers' newspapers, CLE binders, etc. More knowledge in this area will mean more money for your clients.

Try to identify past benefits that reasonably ought to have been paid, even if they were never submitted. Common examples include attendant care and housekeeping performed by family members for the time immediately following the accident. These claims for past benefits potentially add value to the settlement, and any time that you can argue that some unpaid benefit attracts interest at 2% per month, compounded monthly, you can increase the insurer's exposure.

The crystal ball

How do you figure out what medical, rehabilitation and attendant care expenses your client will have in the future? A crystal ball would be nice, but most of us settle for a future care cost report (F.C.C.). You will require the information contained in such a report in most cases before commencing settlement negotiations. The F.C.C. report is prepared by a rehabilitation expert who will review the medical documents, meet with your client and then provide a list of all expected medical, rehabilitation or other related expenses for the balance of your client's life. This report should include a chart that sets out the expected yearly cost of each of the expenses. This chart will allow you to calculate the present value of each of the expenses, to get an idea of how much money your client needs, today, to pay for the expenses for the rest of his or her life. Don't rely exclusively on the F.C.C. report. Read the medical evidence yourself and rely on common sense. It is not unusual for an expert in this field to leave out necessary items. If you don't see something that you expected on the list, call your expert and ask him or her to explain. You should also use common sense and your knowledge of the *Schedule* to critically analyze the contents of the report. Would your client have continued to shovel her own driveway into her

seventies if it were not for the accident? Does the F.C.C. report make claims for items beyond the monetary or time limits provided under the *Schedule*? If common sense or the *Schedule* tells you that you should not be making a certain claim, then discount the offending part of the report. It is often useful to begin the review of the F.C.C. report in negotiations with the insurer by telling them which of the items you believe to be unreasonable. It usually takes the wind out of the sails of the insurer's best arguments and shows them that you are trying to arrive at a reasonable resolution of the claim.

Some counsel are concerned about the cost of an F.C.C. report, if the case doesn't settle. Under the current system of pre-approval for s. 24 assessments, this is a real risk. However, if s. 24 and 38.2 of the *Schedule* are strictly adhered to, and if the report is properly prepared and comments on your client's immediate needs as well as the future needs, at least part of the report will be paid under s. 24. Alternatively, we often try to induce the insurer to pay for a F.C.C. report by coming to an agreement upon the identity of the assessor, and making it explicit that the report is not binding on either the insurer or the insured. It is simply a starting point for the negotiations.

Structure your figures

Once you have your numbers from the F.C.C. report, your income replacement benefit figure, and any other information regarding your client's present and future entitlements to benefits, an actuary or a structured settlement expert can help you determine how much money you need today to create an income stream to cover these benefits. The insurer will likely have this information, so there is no reason for you to go into the negotiations unprepared.

Some lawyers like to hire an actuary, or try to do their own discount calculations, using standard actuarial tables. However, the amount of money that would be required to fund your client's future benefit payments through a structured settlement is often less than the figures that one would arrive at using standard actuarial tables. Since the insurer is under no obligation to provide a lump sum payment for all future benefits (unlike a tort claim), they will likely want to cash out based on the actual cost of the structure, not based on the present value calculations. Be aware that you and the insurer may agree in principal on all of your client's future needs, and still be far apart at the end of the day if you are using different methods to arrive at the final numbers.

There are a number of other reports that you might want to consider on a case by case basis (housing, attendant care, etc.), but attention to the *Schedule*, the F.C.C. report, the medical documentation and the actuarial or structure documents should give you a sufficient foundation in most cases.

Creating risk

Settlements for insurers are all about cost and risk. If the insurer can settle a claim for an amount of money that is reasonable based on the risk of having to make future payments, as well as the cost of continuing to adjust, litigate or arbitrate the file, the case will likely settle. The key for the insured is creating risk for the insurer, in order to maximize the settlement value for the case. Wherever possible, try to take the case to the "next level". For example, what appears to be a WAD I or II claim, with very limited settlement potential, may be settled for a higher amount if there is some reasonable suggestion that the client has more than just WAD injuries. While neck

and back pain may have been the client's initial complaints, it may not be correct to classify them as having only WAD injuries if their symptoms continue. Effort must be taken to take the client out of the WAD *Guideline* and PAF in order to maximize the settlement value of the claim, given the draconian restrictions on the availability of all benefits under the *Schedule* for persons so categorized. Neurological problems, other physical problems, mild head injuries and psychological problems are often overlooked and misdiagnosed, especially where the person initially complains only of pain in the back and neck. Some credible examinations in this respect will create significantly more risk for the insurer, and should also increase their appetite for settlement.

The issue of whether or not your client has sustained a Catastrophic Impairment can also create significant risk for the insurer. Every reasonable attempt should be made to have the client's injuries classified as Catastrophic. The first step is for counsel to clearly understand the criteria under which the client can be considered Catastrophic, especially the provisions of the American Medical Association's *Guides to the Evaluation of Permanent Impairment*. In practice, the physical components of the Catastrophic criteria have been difficult for most accident victims to meet. However, there is significantly more flexibility, and subjectivity, in the mental and behavioural disorders section of the *Guides*. In the right case, this is an area where significant risk can be created for the insurer. There is very little cost involved in having an Application for Catastrophic Determination prepared and submitted to the insurer, in order to force the issue. The strength of the reports will dictate the corresponding risk for the insurer, and leverage for your client to obtain a larger settlement.

The Process

The case is ripe for settlement, and it has been thoroughly worked up. The time is right to settle the claim. How do you get the insurer to discuss the case with you?

There is nothing wrong with approaching the insurer to ask if they want to try to settle the claim. It is not a sign of weakness or desperation. Anyone working in this area knows that lawyers and insurers like to settle cases, so you do not risk losing face by asking the insurer to meet with you. The insurers often take the initiative by holding "settlement conferences", wherein counsel are invited to short settlement meetings, usually at a hotel or conference centre. The insurer invites as many people as possible to these conferences, and the sole purpose is to settle as many claims as possible over a short period of time. If you haven't been invited, call the adjuster and ask for an invitation. This is an excellent opportunity to resolve the claim. The decision maker is almost always within a few short steps of the conference room, and in the mood to settle. The key to these meetings is to be succinct and prepared to get right into the numbers. Starting with the "pie in the sky" figures is not generally effective at these meetings. Be prepared to cut to the chase, and don't leave the meeting without getting a settlement figure from the insurer. They will usually pay a slight premium at these meetings in order to close as many files as possible. The standard settlement meeting is always an option. However, over the past number of years there has been a tendency for insurers to attend these meetings to listen, but not respond. When arranging such a meeting, make sure that you know the scope of the discussion in advance. Is the insurer prepared to settle the file, or do they just want to hear what you have to say? Is someone with authority coming to actually make an offer, or are they going to go away to think about it? These factors will give you an indication of how serious the insurer is taking the

settlement meeting, and how you should approach the discussion of settlement figures at the meeting.

Many cases are settled by way of a formal mediation. While this is a good way of settling cases, it is very different than the other types of meetings previously discussed. Lawyers and clients are almost always in the room together. This makes for a more thorough discussion of the issues, and often more showmanship. Clients must be well prepared for the opening statements, or you risk having the client soured about the process before the negotiations even begin. The mediation experience has, unfortunately, created a number of preconceived expectations for the parties who regularly attend them - they are expected to be long (they don't have to be); they are expected to include 5 or 6 exchanges of offers (3 is often plenty if everyone is serious about settling the case); they are expected to conclude in a settlement (which is not a necessary outcome). Make sure that your client is prepared for all aspects of the mediation, and that you have a plan that will either produce a settlement, or that will extricate you and your client from the negotiations before you put your bottom line on the table.

Dot the "i"s and cross the "t"s

Once you have a settlement in principal, make sure that you cover off all ancillary issues before finalizing the settlement. Things like costs and disbursements, Guardianship costs, Court approval, etc. must be considered at the time of settlement, or ignored at great risk to the lawyer. Simple things such as the time within which settlement monies ought to be paid should be covered off to avoid unnecessary disputes. If the settlement is going to be structured, issues such as the identity of the structure company, the ownership of the structure and any reversionary

interests or guarantee periods must be firmed up before the settlement is finalized. Failure to do so may cost your client and their family a considerable sum of money, and will certainly cost the lawyer considerable aggravation. While many of these issues are beyond the scope of this paper, a structured settlement broker should be brought into the discussions early on to provide advice on these and other related issues, where appropriate.

Conclusion

Settlements are good. A fair settlement is usually in the best interest of all parties. However, one must never forget that every case does not necessarily have to settle. A lawyer should never be afraid to say “no” (or to recommend that a client say “no”) to what the insurer says is their best, and final, proposal. While a tort claim must either result in a settlement or a trial, AB claims have a third option – the payment of benefits for the duration of the insured person’s life, or at least until the benefit period in the policy expires. There are many occasions when the client is better off leaving the claim open than settling for what the insurer says is their last offer. Following some of the steps and ideas set out in this paper will help to determine when and for how much an AB claim ought to be settled, but also when your client is better off not settling the claim at all.

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