

NEGOTIATING SETTLEMENT OF ACCIDENT BENEFIT CLAIMS:
GETTING THEM SETTLED AND KEEPING THEM SETTLED

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For many lawyers, accident benefit claims are a daunting proposition – a mountain of paperwork, a complicated statutory regime and clients who are likely to call weekly, if not daily. Lumping out the claim is seen as the light at the end of the tunnel. The client can get some money in his or her pocket, the insurance company will get off of everyone's back, and the lawyer can get paid. However, knowing how, or when, to properly lump out a claim for accident benefits is both an art and a science. This paper will focus on two main aspects of lumping out accident benefit claims; getting them settled and keeping them settled.

GETTING THEM SETTLED – To lump out or not to lump out, that is the question

Not every case is capable of being settled. In order to consider lumping out an accident benefit claim, the lawyer must be 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.

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 with some certainty about what the future may hold, it's

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 distributed. If there is no one appropriate to act as a Guardian, the Public Guardian and Trustee will get involved in the case. In our experience, this is something that counsel should try to avoid, as sometimes delay can result from involving this government body. Family members are often the most appropriate guardians of a mentally disabled person's assets.

Is there a tort action?

There can be considerable overlap between the tort and accident benefit 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. This provides the tortfeasor with the ability to argue that the injured person settled his or her claim for statutory accident benefits for an amount less than what was reasonably available to them. Arguments in this respect regularly arise under O.M.P.P. claims, but fortunately the scope of the argument has been somewhat limited by Bill 59. The combination of subsections 267.8(21) and (22) 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". However, the argument can still

be raised when there is no denial of benefits, so counsel must be very careful when lumping out a claim that is still being paid by the accident benefits insurer. In any event, the client should be informed, in writing, of the risks associated with settling an accident benefit claim before disposition of the tort action.

GETTING THEM SETTLED – Lumping out

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. We recommend considering three main areas before turning on your calculator.

Read the *Schedule*

We have had in Ontario four different accident benefit schemes in the past 11 years, the last three of which (O.M.P.P., Bill 164 and Bill 59) are set out by different *Statutory Accident Benefits Schedules*. There are major differences between the systems that will be obvious after a brief review of the different Regulations. 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. Then, research the decisions, both arbitration and judicial, as the law in this area is constantly affected by new decisions. A collateral benefit that was deductible from your client's accident benefits a few months ago might not be deductible today. Claims that were routinely accepted for care provided by family members may not be paid by an insurer today. Keep abreast of the law by reading everything that you can; the

Ontario Reports, the lawyers' newspapers, CLE binders, etc. More knowledge in this area can mean more money for your clients.

The crystal ball

How do you figure out what medical and rehabilitation 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.), also known as a future needs analysis. You will require this type of report in almost every case before commencing settlement negotiations. Very simply, 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 a necessary item. If you don't see it 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 available under the *Schedule*? If common sense or the *Schedule* tell you that you should not be making a certain claim, then discount the offending part of the report. We generally begin our review of the F.C.C. report in our negotiations with the insurer by telling

them which of the items we believe to be unreasonable. It usually takes the wind out of the sails of their best arguments and shows them that we 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.

However, if the report is properly prepared and comments on your client's immediate needs, it can be considered to be a section 24 examination (Bill 59 only) and therefore payable by the insurer in any event.

Structure your figures

Once you have your numbers from the F.C.C. report and your income replacement benefit figure (assuming a Bill 59 case) an actuary or a structured settlement expert can help you determine how much money you need today to create an income stream to cover your client's medical, rehabilitation and income replacement benefits in the future. The insurer will likely have this information, so there is no reason for you to go into the negotiations unprepared.

Some lawyers like 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 is often less than the figures that one would arrive at using the 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 lump 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 and the actuarial or structure documents should give you a sufficient foundation in most cases.

KEEPING THEM SETTLED – The Settlement Regulation

The “Settlement Regulation” (§9.1 Ontario Regulation 664 as amended by Ontario Regulation 780/93) has governed the settlement of accident benefit claims for more than seven years. Until relatively recently, all of the jurisprudence under §9.1 came from arbitrators at the Financial Services Commission of Ontario (“FSCO”). The arbitrators generally gave §9.1 a broad and liberal interpretation, often permitting insured persons to rescind settlements entered into with insurance companies.

As far as we can tell, it took four years for a consideration of §9.1 to come before the Ontario Courts. However, since late 1998, the Courts have been called upon to interpret the Settlement Regulation on more than ten occasions (and counting). At first, the results were conflicting and somewhat unsatisfying, but the Courts now seem to be moving in the direction taken originally by FSCO arbitrators. This paper will attempt to bring the reader up to date on the state of the law on the Settlement Regulation in the Ontario Courts.

The actual text of §9.1 has been appended to this paper. To summarize, when a settlement of statutory accident benefits is proposed, the insurer must provide a description of the benefits available, a description of the impact of the settlement (i.e. a restriction on the right to litigate, arbitrate, etc.), a statement that the insured retains the right to rescind the settlement within 2 business days (the “cooling-off period”) and a statement advising the person to consider seeking

independent legal, financial and medical advice. Finally, where the settlement provides for a lump sum payment for a benefit that is not a lump sum benefit (in other words, lumping out a future obligation to pay), the insurer must provide an estimate of the commuted value of the benefit and an explanation of how the insurer determined the commuted value. If the insurer fails to give the insured a settlement document containing all of this information, the insured can rescind the settlement at any time.

Generally speaking, our Courts like settlements. The idea that a person can rescind an informed settlement that has been voluntarily entered into does not sit well within a system that encourages settlements at every possible turn. Contract law is founded on the principles of “offer and acceptance”. Rule 49 is founded on the same principles. Counsel in this field presumed that the Courts might have a hard time with the idea of “offer, acceptance and rescission”. They were right.

Pre-Opoku

When this issue first came before the Court, warning bells sounded. The facts of *Cordova v. Allstate Insurance Co. of Canada* (1998), 41 O.R. (3d) 795, are straightforward. A claim for accident benefits was settled. The insurer provided the settlement documents, which did not include a “statement of the restrictions contained in the settlement on the insured person’s right to mediate, litigate, arbitrate, appeal or apply to vary an order” (§ 9.1(2) paragraph 2). The insured person later attempted to rescind the settlement, based in part on the failure of the insurer to provide this statement in the settlement documents. Justice Somers concluded that he was, “unable to give effect to the settlement apparently arrived at. I may say I do so with some reluctance, but I have concluded that a statutory procedure must be followed in order for the

settlement to be binding” (at p. 799). You might surmise that Justice Somers was reluctant to enforce the clear terms of the statutory procedure due to a preference to encourage final settlements. This general preference was also revealed in several of the following cases.

Opoku

The main exception to this judicial preference was found in *Opoku v. Pal* (1999) 49 O.R. (3d) 97, affd 49 O.R. (3d) 97 (C.A.). This case involved a quadriplegic young man, whose lawyer attempted to settle both his tort claim and his claim for accident benefits for a lump sum (approximately \$1.75 million). The settlement documents included what purported to be a “commuted value” statement, but was in fact only a description of the various maximum insurance limits available under each heading. After we were retained, we rescinded the “settlement” and argued that the description provided by the insurer did not comply with the Settlement Regulation. Justice Spiegel found that, in order to comply with the commuted value requirement of §9.1(2) paragraph 5, the insurer should have provided:

- a) Mr. Opoku’s life expectancy;
- b) the appropriate discount rate in respect of each of the periodic benefits;
- c) the insurer’s assumptions concerning the rate at which the med/rehab benefits would be paid over the course of Mr. Opoku’s life; and
- d) the insurer’s assumptions concerning the rate at which the attendant care benefits would be paid over the course of Mr. Opoku’s life (at p. 114).

Justice Spiegel held that, since the insurer did not comply with the Settlement Regulation, Mr. Opoku was entitled to rescind the settlement. Since the same insurer purported to settle the tort

claim and accident benefits claim in the one lump sum (the same insurer had responsibility for both claims), the tort settlement was set aside as well.

On appeal, the Court of Appeal affirmed Justice Spiegel's decision. The Court did comment that an insurer is not required to resist settlement until all possible information is available to assist them in the commuted value calculations. So long as the insurer makes an assessment in good faith (emphasis added) based on the information available to it, and provides the factual assumptions relied on to calculate the commuted value, the insurer will have complied with the Settlement Regulation.

Following *Opoku*, there was a real fear in the insurance industry that most of the approximately 50,000 settlements (the number suggested in the affidavit material in *Opoku*) that had been entered into were now voidable. It is common knowledge that insurers routinely provided the same type of insufficient commuted value calculations in their settlement documents that were at issue in *Opoku*. At a minimum, the decision made for a lot of uneasy actuaries and insurance company executives.

Post-Opoku

Actuaries and insurance claims handlers' concerns were somewhat eased following the case of *Catania v. Scottish & York Insurance Co.*, [1999] O.J. No. 3678. In this case, the settlement involved a lump sum payment of \$8,399.00. Ms. Catania attempted to rescind the settlement, based on the *Opoku* decision and the fact that there was no commuted value calculation provided in the settlement documents. The settlement was not really a lump sum payment intended to cover a lifetime of benefits. Instead, it was a payment of past income replacement benefits for a period of six months (\$6,000.00), plus payment for some limited psychological treatment

(\$2,000.00) and some medical reports (\$399.00). Justice Dambrot did not take any issue with the approach in *Opoku*, but found that it had no meaningful application to this particular case. It was found that Ms. Catania's life expectancy, the appropriate discount rate, etc. were totally irrelevant to the settlement at issue. As a result, the settlement was upheld. Were the courts now distinguishing between a \$1.75 million settlement that could be rescinded and a \$8,399.00 settlement that could not be rescinded?

Fortunately, the decision in *Catania* was appealed, and the Court of Appeal has now set the record straight (Docket C33074, February 28, 2001). The Court quoted extensively from *Opoku* and concluded that the insurer in *Catania* had made no effort whatsoever to provide much of the information required by the Settlement Regulation. Neither the amount of the settlement, nor the fact that the settlement did not provide for a lump sum to cover a lifetime of expenses, precluded the insurer from having to comply with the Settlement Regulation. The Court did make an interesting comment in this case about the materiality issue. The insurer argued that the failure to provide the information had no bearing on the plaintiff's decision to enter into the settlement. The Court concluded that, "This, however, is not the test in a case such as this where there has not been even minimal compliance with the regulation. (It could be a factor to take into account in a case where there is some degree of compliance.)" It remains to be seen how the materiality argument will play out in a case where there has been minimal compliance with the Settlement Regulation by the insurer.

Following *Opoku*, some insurers were asking Plaintiff's counsel to prepare the settlement documents, in the hope that this might preclude the injured person from later claiming that the documents did not comply with the Settlement Regulation. The Court of Appeal has apparently

put an end to this argument, in commenting that, "...it is entirely within the hands of the insurance companies to see that there is compliance with (the Settlement Regulation)".

Where the settlement documents are not defective, the Plaintiff still has the unilateral right to rescind the settlement within the 2 day cooling-off period (§9.1(3)). This cooling-off period was the subject matter in *Birjasingh v. Coseco Insurance Co.*, [1999] O.J. No. 4546. In this case, the settlement was agreed to between counsel, with instructions from their clients. The settlement documents (which were not alleged to be defective in any way) were sent to Plaintiff's counsel. Ms. Birjasingh never actually saw the documents, and when she discovered (some months later) that she would require further surgery, she instructed her lawyer to attempt to rescind the settlement. This rescission was based on a line of FSCO decisions holding that, until the insured is physically "given" the settlement documents, as required by §9.1(2), the 2 day cooling-off period does not begin to run. Justice Nordheimer refused to follow the line of cases from FSCO and as a result refused to set aside the settlement. The FSCO cases were based on the reasoning that, to give meaning to the 2 day cooling-off period, the insured must actually get the settlement documents and then consider his or her options for two days. Justice Nordheimer instead relied upon the law of agency, holding that "communication of a matter to the solicitor is, in effect, communication of that matter to the client" (at par. 11). Underlying this decision is Justice Nordheimer's conclusion that the Settlement Regulation was enacted to address, "situations where unrepresented insureds were agreeing to quick settlements offered by insurers"(at par. 12). It should be noted that §9.1 is silent on the issues of legal representation and the speed of the settlement. In fact, this same argument was raised by the Defendants in *Opoku*, before the Court of Appeal, without success. In any event, as the law now stands, the 2 day cooling-off period

begins to run when the insured's lawyer receives the settlement documents. A suggestion to Plaintiff's counsel; either see your client very quickly, or if you choose to rescind, use FSCO arbitration rather than the courts as a method of dispute resolution.

What happens to the settlement funds when an insured attempts to rescind a settlement? The Court of Appeal concluded that the funds are immediately owing to the insurer in the case of *Stephan v. Insurance Corporation of British Columbia* (2000), 48 O.R. (3d) 41. However, the Court did not make the rescission dependent upon the return of the settlement funds, as had been suggested by the insurer. Presumably the issue would be dealt with by a claim for set-off, or an action for repayment, after the settlement is rescinded.

The issue that seems to be the most controversial in the Courts is the interplay between §9.1 and Rule 49. Both the trial level decisions in *Kibalian v. Wellington Insurance Co.*, [2000] O.J. No. 1689, revd 52 O.R. (3d) 92 (Div. Ct.), and *Jimenez v. Markel Insurance Co. of Canada* (2000), 49 O.R. (3d) 402, conclude that, "s. 9.1 and Rule 49 cannot work in tandem" (*Kibalian*, [2000] O.J. No. 1689 at par. 7). In *Kibalian*, an offer was made and accepted pursuant to Rule 49.

Before the insurer's lawyer sent any of the settlement documents required by §9.1, the insured's counsel rescinded the settlement. Justice Jennings, in refusing to permit the Plaintiff to rescind the settlement, found that, "the plaintiff by choosing to proceed under Rule 49 had waived the provisions of the Insurance Act" (at par. 21). His Honour further found that, to permit a 2 day cooling-off period after the acceptance of a settlement, "is to make a mockery of the Rule 49 procedure" (at par. 17).

Although the decision in *Kibalian* was later overturned on appeal, this line of reasoning was quoted with approval in *Jimenez*, in obiter. That case involved a claim for accident benefits that

was settled at a FSCO mediation. The next day (during the 2 day cooling-off period) the clients informed their lawyer that they wanted to rescind the settlement. Their lawyer did not properly advise the insurance company of this fact until more than one month later. Justice Campbell framed the issue as follows, “should the remedial aspect of the regulation be construed to protect and benefit an insured when a settlement is accepted and not objected to by an errant solicitor” (at p. 410). Put that way, it is not difficult to predict that Justice Campbell did not have a lot of sympathy for the Plaintiff’s position, and therefore refused to permit them to rescind the settlement.

Justice Matlow came to the opposite conclusion regarding Rule 49 in *Igbokwe v. HB Group Insurance Management Ltd.*, [2000] O.J. No. 4637. In this case, Mr. Igbokwe (incidentally himself a very experienced accident benefits insurance adjuster) and his lawyer made an offer to settle all of his claims for accident benefits directly to his insurance company, including a term that costs were to be agreed upon. Shortly thereafter, they received a reply from counsel for the insurer (who, of interest, is the same insurer from both the *Opoku* and *Birjasingh* cases) in a related bad faith action purporting to accept the offer of settlement, and telling Plaintiff’s counsel that he would have to assess his costs. Plaintiff’s counsel rescinded the settlement. No settlement documents had been delivered by the insurer. Justice Matlow explicitly rejected the previous cases and held that, even if the case was settled under Rule 49, the Settlement Regulation still applied. Mr. Igbokwe therefore had the benefit of the 2 day cooling-off period, which never actually began to run since the insurer had never delivered the settlement documents.

Igbokwe was referred to with approval by the Divisional Court in the appeal of *Kibalian*.

Although the Court agreed that the Settlement Regulation "...causes some interference with the provisions in the Rules relating to settlement", the Court concluded that it still applies to cases where an action has been commenced. The Court commented that, had the insurer delivered the proper settlement documents at the time of accepting the insured's offer, the settlement would have become complete after the cooling-off period had expired. Since no such documents were ever sent by the insurer, the insured was entitled to rescind the offer and the decision of Justice Jennings was therefore overturned by the Divisional Court.

Igbokwe is currently under appeal. This area clearly requires some clarification. Keep in mind that while our courts may favour cases being settled, if the rules can be bent to force settlement where it seems none was clearly intended, this may bring about the opposite effect. If discussions or proposals are interpreted to force settlements, then real settlement discussions and negotiations may be avoided, thereby inhibiting settlements from occurring! One would hope that the Court will consider the often overlooked Rule 1 (specifically Rule 1.02(1) paragraph 3), which states that, "These rules apply to all civil proceedings...subject to the following exceptions: ...They do not apply if a statute provides for a different procedure." In this case, a statute clearly provides for a different procedure. Section 279(2) of the *Insurance Act* and the Settlement Regulation appear to supercede Rule 49, and therefore insureds should be able to maintain their right to the 2 day cooling-off period.

The Settlement Regulation will continue to provoke litigation and uncertainty, and well thought out and informed settlements will require careful work on the part of counsel.

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Settlements – Statutory Accident Benefits

(Ontario Regulation 664 as amended by Ontario Regulation 780/93)

9.1 (1) In this section, “**settlement**” means an agreement between an insurer and an insured person that finally disposes of a claim or dispute in respect of the insured person’s entitlement to one or more benefits under the *Statutory Accident Benefits Schedule*.

(2) Before a settlement is entered into between an insurer and an insured person, the insurer shall give the insured person a written notice that contains the following:

1. A description of the benefits that may be available to the insured person under the *Statutory Accident Benefits Schedule* and any other benefits that may be available to the insured person under a contract of automobile insurance.
2. A description of the impact of the settlement on the benefits described under paragraph 1, including a statement of the restrictions contained in the settlement on the insured person’s right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act.
3. A statement that the insured person may rescind the settlement within two business days after the settlement is entered into by delivering a written notice to the insurer.
4. A statement that the tax implications of the settlement may be different from the tax implications of the benefits described under paragraph 1.
5. If the settlement provides for the payment of a lump sum in an amount offered by the insurer and, with respect to a benefit under the *Statutory Accident Benefits Schedule* that is not a lump sum benefit, the settlement contains a restriction on the insured person’s right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act, a statement of the insurer’s estimate of the commuted value of the benefit and an explanation of how the insurer determined the commuted value.
6. A statement advising the insured person to consider seeking independent legal, financial and medical advice before entering into the settlement.

(3) A settlement may be rescinded by the insured person, within two business days after the settlement is entered into, by delivering a written notice to the insurer.

(4) If the insurer did not comply with subsection (2), the insured person may rescind the settlement after the period mentioned in subsection (3) by delivering a written notice to the insurer.

(5) A restriction on an insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act is not void under subsection 279(2) of the Act if,

(a) the restriction is contained in a settlement; and

(b) the insurer complied with subsection (2).