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Financial Considerations for Accident Victims

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The primary goal of every personal injury lawyer is to help his or her clients obtain maximum compensation for their losses. Unfortunately, serious injury claims involving traumatic brain injury often take years to advance through the litigation system. Understanding a client's financial situation and how it may influence the litigation is therefore imperative.

There are tools available to clients in the immediate months and years following an accident that ensure their financial survival. These include advance payments, 3rd party litigation financing, workplace disability benefits and disability benefits plans, as further described below.

At the Beginning of the Claim:

In my initial meetings with clients and family members, a key goal of mine is to understand my client's financial situation in order to investigate potential financial resources available to protect them.

One option that may be available is workplace disability benefits. Many clients are unaware of the coverages available under their workplace benefits plans so benefits plan information must be obtained. Moreover, the statutory accident benefits insurer ("SABs" insurer, in motor vehicle cases) will insist on reviewing these coverages before paying any benefits as workplace benefits must be accessed in priority to no-fault accident benefits.

When disability benefits are available, a review of the coverages and disability definitions is required. Most plans contain a period of short-term disability (STD) coverage, normally followed by long-term disability (LTD) benefits coverage up to 104 weeks and continuing thereafter with a more stringent disability benefits test. Typically during the initial 104 weeks, an insured can access benefits if they cannot perform the essential aspects of their own occupation. After 104 weeks, there is usually a change in definition that requires the insured to be unable to perform any occupation for which they are reasonably qualified in order to continue receiving benefits. In most cases, policies pay 65%-70% of pre-accident income.

Disability benefits plans may contain coverages that help in the aftermath of a severe trauma. Good plans (which are rare) may provide a benefit in the event of dismemberment or critical illness and a brain injury may qualify. They may also provide specified benefits, such as personal support worker assistance, convalescent care, housing/vehicle modification allowances and the like.

While disability benefits needs to be explored when available, in motor vehicle cases, applications must be submitted promptly to the SABs insurer. These applications must be submitted within 30 days of an accident though extensions may be available in serious injury cases.
The SABs insurer will pay a weekly income replacement benefit ("IRB") if the insured was employed at the time of the accident or in receipt of employment insurance benefits at the

time of the accident or not currently employed but employed for at least 26 out of 52 weeks prior to the accident, and unable to work. Unless optional benefits have been purchased, the maximum IRB is a modest $400/week and, like LTD, there is a change in the disability test after 104 weeks of disability that makes accessing the IRB more difficult and often leads to the termination of benefits at that stage.

The SABs insurer calculates the benefit amount and may engage an accountant to do so. I often find that the insurer's calculations understate the weekly benefit amount. Under the SABs, the insured person may retain its own accountant, at the insurer's expense, to calculate the proper benefit amount. Many insured's do not take advantage of this, however consideration should be given to retaining an accountant in all cases to calculate the weekly benefit to ensure compensation is maximized.

Under current Ontario legislation, individuals who were not employed at the time of the accident (e.g., students and retirees) are restricted to claiming a non-earner benefit if they meet the stringent non-earner benefit test of suffering a "complete inability to carry out a normal life." This benefit starts 30 days after an accident, is only payable for up to 2 years and provides modest assistance of $185/week.

Some victims may be eligible for government support plans like the Ontario Disability Support Plan ("ODSP"). To qualify for ODSP, a victim must meet the plan's disability test and be in financial need. The disability test requires that the victim have a substantial mental or physical impairment that is continuous or recurrent and expected to last more than one year, the impairment must directly result in a substantial restriction in the ability to work, care for oneself, or take part in community life, and the impairment must be verified by an approved health practitioner. When ODSP support is available, it will be reduced by the amount of any IRB or non-earner benefit received so it may not have net financial impact for the client. It may also need to be repaid at the time of settlement.

The Canada Pension Disability Benefit ("CPP-D") is available to individuals who have contributed to CPP for at least 4 of the past 6 years or 3 of the last 6 years if they have contributed for at least 25 years. Applicants must meet the test of suffering a "severe and prolonged" disability to qualify. Severe is defined as "incapable of regularly pursuing any substantially gainful occupation." Prolonged is defined as "likely to be long, continued and of indefinite duration or is likely to result in death." Receiving CPP-D may reduce the IRB entitlement and CPP will be deducted from any STD/LTD entitlement under most plans.

There are other financial benefits and tools that may be available such as disability tax credits and disability savings plans, which clients should consider applying for. There are companies that specialize in financial management for accident victims who provide financial planning and assistance to access all of these benefits at the insurer's expense. I recommend these companies to clients that need a financial management plan early on so they are not met with unexpected surprises as the claim progresses.

As the Claim Progresses

In serious injury claims involving traumatic brain injury, there usually comes a time when the medical/rehabilitation SABs coverages are exhausted. This is especially the case where a client cannot meet the restrictive tests for catastrophic impairment benefits that have been in place since June 1, 2016 and is thus limited to only $65,000.00 in non-catastrophic benefits coverage.

The exhaustion of SABs coverage should be anticipated by treatment providers and clients, as insurers need to send out benefit statements every 60 days. Unfortunately, many insurers don't send out these statements. Case managers should ask to see these statements so that funding issues stay top of mind. Sometimes statements arrive but the information in them cannot be relied on because they only reflect amounts paid and do not include services that have not been invoiced by health care providers. In that regard, I encourage health care providers to submit invoices promptly so that funding issues do not surprise clients.

There are situations in which an insurer approves more than the maximum medical/rehabilitation benefit amount and then refuses to pay providers once the limits have been reached. When the denial (of the approved service) arrives, the provider is left unpaid for approved services placing additional stress on clients. In a recent case with a leading insurer, my complaints about this irresponsible claims management issue led to the insurer reversing its decision and properly paying for all approved services above the maximum limits.

When accident benefits funding runs out, there are several options for clients to explore. A catastrophic application is one such option, however, it is not available in all cases and even when it is pursued successfully, the catastrophic application and insurer review process can take many months. One benefit of submitting a catastrophic application ("OCF-19") is that the insurer must continue paying attendant care benefits (though not medical/rehabilitation benefits) at the existing Form 1 amount upon receipt of the OCF-19, up to the insurer's final catastrophic determination. Thus, where funding is running low and attendant care benefits are critically required, consideration should be given to having a physician complete an OCF-19 early on to preserve the attendant care benefit.

There is often discussion with clients and rehabilitation providers at this stage about "protected accounts." There are sometimes misconceptions about what a "protected account" is. A protected account is an arrangement between an accident victim and a provider for the provider to be repaid out of settlement proceeds. The lawyer is not a party to the arrangement, though it is a good idea for both clients and providers to discuss the arrangement with the lawyer so that its implications are understood and that it is followed. The challenge is that many providers cannot work on these deferred payment terms for understandable reasons.
When a provider can work under these terms, lawyers require a direction from the client authorizing the provider to be repaid at the time of settlement. When entering into this type of arrangement, the provider must understand that they bare the risk of non-payment if the client does not make a financial recovery. It is in the provider's right to charge interest on these

accounts. The provider must also ensure that if there is a change of counsel that the direction the client signed be brought to the attention of the new counsel. Companies like Bridgepoint also offer different types of litigation loans, including loans to pay for treatment where a victim has exhausted their medical/rehabilitation limits.

Another tool that plaintiff lawyers often pursue is advance payment demands from the tort insurer. In motor vehicle cases the tort insurer is statutorily obliged to try to resolve the claim as expeditiously as possible. In rare cases, when an insurer admits liability for all or part of a claim for income loss, the insurer shall make advance payments to the person making the claim pending a determination of the amount owing. This tool can sometimes help but clients should not get their hopes up as insurers rarely make this admission. However, insurers are sometimes willing to make advance payments if the lawyer and rehabilitation team can demonstrate it is in their interest to do so (i.e., where the client will be forced to discontinue important treatment without funding that could lead to a deterioration in their condition).

When an insured has exhausted their SABs medical/rehabilitation benefits, I typically write to an insurer on behalf of my client requesting an advance payment and, where appropriate (and well documented by the rehabilitation team), explain how the failure to provide such a payment will lead to the termination of services and a likely deterioration in my client's health. In any case in which the same insurer is handling the SABs and tort claim, the SABs insurer's willingness to pay for ongoing benefits including IRBs will be compelling evidence to highlight for the tort insurer, from the same company, when seeking an advance payment. While an insurer cannot be forced to provide an advance payment, the *Insurance Act* states that a failure to do so may be taken into consideration when assessing costs after a claim is resolved.

In motor vehicle claims, an insurer must participate in mediation at the insured's request and at the insurer's expense within as little as a month after the request is made. Most counsel do not rely on this requirement when scheduling mediations, however this mediation obligation can be used to apply pressure to insurers who are non-responsive to claims that require immediate attention.

After the Settlement

Cases settle at all stages of the litigation process. While most cases settle at the mediation stage usually a few years after an accident, there are many claims that settle much earlier and some that go on well beyond that timeline.

In cases involving traumatic brain injury, a client's capacity issues may result in a requirement that Court approval be obtained for any settlement. In any Court approval application, the Court will usually insist that settlement funds be structured before approving the settlement.

I encourage clients receiving large sums of money to structure their settlement funds. When money is received in a lump sum it can easily be forgotten that the money was intended to

purchase medical services or replace future income over many years. For clients recovering from traumatic brain injury and suffering ongoing cognitive issues, a financial plan is absolutely required at the time of settlement to ensure that funds are properly managed.

Clients who have had a financial plan in place over the years of their litigation, perhaps including an advisor helping along the way, are more likely to understand the importance of proper financial management once their claim is finally resolved.

What this means for you and your clients?

Clients need to understand from the outset the financial issues that may arise and the prolonged time lines for most litigation claims. Financial management and budgeting should be emphasized as clients will inevitably have financial restraints throughout their recovery. Understanding these restraints and the different tools available to try to address them will hopefully help alleviate anxiety when the financial crunch arrives.