Collateral Benefits:
The Basics to Know When Settling a Personal Injury Claim

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PART I - INTRODUCTION

One of the daunting tasks of being a personal injury lawyer is managing collateral benefits, particularly when considering settlement of a tort or accident benefit case. For instance, if we forget to notify a potential subrogated entity of the litigation, then our client may remain on the hook for repayment; or if we provide a deduction for a collateral benefit when the Defendant was not entitled to such an offset, then our client may be under-compensated. There are many nuances to the issue of collateral benefit deductions, assignments, and subrogated claims; and there are key differences in the treatment of these benefits between non-motor vehicle and motor vehicle cases. This paper will offer a basic overview of the collateral benefit issues to consider when it comes time to settling a personal injury claim.

PART II - TERMS DEFINED

For purposes of this paper:

- Collateral benefits will generally refer, unless specified, to benefits paid to the Plaintiff/insured which may be relevant to the issue of deductibility, assignment, or subrogation in relation to a tort or accident benefit ("AB") claim. These may include, but not be limited to:

    - Disability benefits [e.g. short-term disability ("STD") or long-term disability ("LTD")];

    - Extended health benefits (e.g. benefits paid by an insurer for medical, rehabilitative, and other goods and services);

    - Canada Pension Plan disability benefits ("CPPD");

- ABs (e.g. benefits payable under the *Statutory Accident Benefits Schedule*[1]);

- OHIP-funded assessments and services.

- A deduction will refer to a discount/rebate/offset/credit (which terms may be used interchangeably) to be given to the opposing side in negotiations on account of collateral benefits that the Plaintiff or insured has received to the point of settlement.

- An assignment will refer to collateral benefits the Plaintiff is likely to receive in future, after the settlement, which benefits may need to be held in trust for and ultimately payable to the Defendant/insurer.

- A subrogated claim will refer to a claim for reimbursement advanced by the Plaintiff against the Defendant, for the benefit and on behalf of, a non-party that has paid and/or is likely to pay collateral benefits to the Plaintiff.

This paper will not cover all possible collateral benefits; in particular, I will not be touching upon Ontario Disability Support Program benefits, benefits paid pursuant to workplace safety legislation, or other government-funded programs (other than CPPD).

PART III - *NON*-MOTOR VEHICLE TORT CASES

A. OVERVIEW OF THE COMMON LAW SCHEME

i. The Common Law Private Insurance Exemption

The treatment of collateral benefits in non-motor vehicle cases is governed by common law.

Compensation under tort law is meant to put the Plaintiff back in the position in which the Plaintiff would have been but for the losses suffered in the incident.[2] It is not meant

1 The current version for accidents on or after September 1, 2020, being O. Reg. 34/10 [the *SABS*].

2 *Andrews v. Grand & Toy Alberta Ltd*., 1978 CanLII 1 (SCC), [1978] 2 SCR 229 at 241.

to offer a windfall to the Plaintiff or to allow the Plaintiff to receive double recovery. A common law exception to that general principle is called the "private insurance exemption".

The private insurance exemption, which initially emerged in the context of LTD benefits received by the Plaintiff, holds that benefits paid pursuant to a private policy of insurance should *not* necessarily be deducted from the Plaintiff's income loss claim. The rationale behind this principle was explained by the Supreme Court of Canada in the case of *Cunningham v. Wheeler*,[3] whereby the Court stated that "there would be no justice in setting off an amount to which the Plaintiff had entitled himself under a contract of insurance such as any prudent man would take." Put otherwise, the Court stated, "it makes little sense for a wrongdoer to benefit from the private act of forethought and sacrifice of the Plaintiff."

Notably, although *Cunningham* dealt specifically with payments for lost wages in relation to a tort income loss claim, the private insurance exemption principle applies equally to other collateral benefits; for instance, extended healthcare benefit payments in relation to a past or future care claim in tort.

The treatment of collateral benefits in non-motor vehicle tort cases comes down to an analysis of whether the Plaintiff has made a "sacrifice", meaning *in some way* paid for, the collateral benefits in order to gain entitlement to those benefits.

ii. Guidance to Determine which Benefits May be Deductible

In *Cunningham*, the Court provided guidance on the type of evidence that could be sufficient to establish that an employee paid for/contributed to the receipt of the collateral benefits paid, by way of a group policy. The Court was careful to note, however, that the following list is *not* meant to be exhaustive:

3 *Cunningham v. Wheeler; Cooper v. Miller; Shanks v. McNee*, 1994 CanLII 120 (SCC), [1994] 1 SCR 359 [*Cunningham*].

1. Wages or Benefits Foregone - Evidence that there were trade-offs in the collective bargaining process, which demonstrate that the employee has forgone higher wages or other benefits in return for the disability benefits. In such a case, the employee has paid for the benefits through wages foregone.

2. Money Foregone - Evidence of some money foregone by the employee in return for the benefits. For example if the employees gave up the return of a percentage of their Unemployment Insurance Plan premiums in return for the benefits.

3. Direct Contribution to Premium - Evidence of a direct contribution by the employee, such as payroll deductions, in return for the benefits. Such a contribution need not be 100 percent of the premium.

4. Part of Wage Package - Evidence of payments made by the employer for benefits, which shows that those payments were part of the employee's wages, and thus the employee provided work for the employer in order to have the premium paid. For example, if the employer's contribution is listed on the employee's pay slip or statement of benefits, it can reasonably be inferred that the contribution is part of the employee's wage package.

In the Supreme Court of Canada's subsequent decision of *IBM Canada Limited v. Waterman*,[4] the Court offered the following further guidance:[5]

- There is no single marker to sort out which benefits fall within the private insurance exception.

- One widely accepted factor relates to the nature and purpose of the benefit. The more closely the benefit is, in nature and purpose, to an indemnity against the type of loss caused by the defendant's breach, the stronger the case for deduction. The converse is also true.

- Whether the Plaintiff has contributed to the benefit remains a relevant consideration, although the basis for this is debatable.

- In general, a benefit will not be deducted if it is not an indemnity for the loss caused by the breach, and the plaintiff has contributed to obtain entitlement to it.

4 2013 SCC 70 (CanLII) [*IBM Canada*].

5 *Ibid*. at para. 76.

- There is room in the analysis of the deduction issue for broader policy considerations such as the desirability of equal treatment for those in similar situations; the possibility of providing incentives for socially desirable conduct; and the need for clear rules that are easy to apply.

B. TREATMENT OF VARIOUS COLLATERAL BENEFITS

i. Benefits under Group/Employment Policies

The *Cunningham* decision related to three separate actions (i.e. different Plaintiffs), all of which dealt with the issue of the potential deductibility of disability benefits from tort income loss awards. In each of the three cases, the Plaintiff had been injured, received disability benefits through a group employment plan negotiated by the Plaintiff's union, and sought to recover 100% of the Plaintiff's income loss claim against the Defendant without any deduction for the collateral benefits received by the Plaintiff.

Where the three cases differed was that some of the Plaintiffs had directly contributed to the cost of the benefit plan by way of premiums being deducted from their salaries, while other Plaintiffs' employers paid 100% of the benefit plan premiums.

Based upon the guidelines outlined earlier in this paper, the Supreme Court concluded that there should be no deduction in the cases where the Plaintiff clearly paid for the benefits by way of premiums being deducted from their paycheques.

The Court also concluded, *based upon the facts and evidence in this particular case*, that even those benefits derived from 100% employer-paid plans should not be deductible, since there was evidence that the collateral benefits were an important part of the compensation package negotiated as part of the collective agreement between the union and employer. More specifically, the evidence showed that had the employer not agreed to provide employees with collateral benefits, then the union would have demanded higher wages as part of the collective agreement. Since the bargain deliberately traded off benefits in lieu of higher wages, the Court considered the benefit plan to have been paid by the employees just as if they had purchased the policy themselves.

The Court explained its rationale as follows:

> To say that the exception applies only to private insurance, where actual premiums are paid to the insurance company, would create barriers that are unfair and artificial. It would mean that top management and professionals who could well afford to purchase their own insurance would have the benefit of the insurance exception, while those who made the same provision and made relatively greater financial sacrifices to provide for the disability payments through their collective bargaining agreement would be denied the benefits of the insurance exception. This would be manifestly unfair. There is no basis for such a socially regressive distinction.

In other words, there are ways, *through evidence*, to demonstrate why even 100% employer-paid benefit plans may not be deductible in *every* case.

The importance of the quality of evidence necessary to apply the private insurance exemption is highlighted in the case of *Sean Omar Henry v. Dr. Marshall Zaitlen*,[6] where the Plaintiff failed to establish a sacrifice or trade-off for receipt of the benefits and, as such, his benefits were deducted from his tort income loss award. The Plaintiff was a member of a union who, as part of the collective agreement with his employer, received long-term disability benefits and was required to enroll in a co-pay pension plan. Upon suffering disability, the employer would continue making its share of the pension contributions. The Court stated:[7]

> Ms. Barnett did not have any direct evidence on the negotiation of any collective bargaining agreement since she joined CUPE Local 79 in 2018. I do not accept that the Plaintiffs established any trade-offs or concessions to obtain benefits through the collective bargaining process…

ii. Benefits under Hybrid Group/Employment Policies

It is not uncommon for employers to *share* premium costs with their employees. In these cases, logic follows that at best, the Defendant would only be entitled to deduct the same percentage as the Plaintiff's employer paid toward the premiums. In other words, the deduction should match the percentage of the employer's contribution.

6 2022 ONSC 2718 (CanLII).

For example, assume: An employer pays 80% of the premium and the other 20% gets deducted from the employee's paycheque; The Plaintiff's gross income loss is worth $200,000.00; and the Plaintiff's collateral benefits are worth $100,000.00. In this scenario, the Defendant should be entitled to deduct 80% of the benefits ($80,000.00) from the tort claim of $200,000.00, netting the Plaintiff $120,000.00. Had the benefits been deducted on a 100% basis, the Plaintiff would have only netted $100,000.00.

iii. Benefits under Private Policies

Not all employers offer the payment or administration of collateral benefits, nor is that type of discussion relevant in the case of self-employed Plaintiffs. Based upon the Supreme Court's rationale, collateral benefit policies that have been privately/independently purchased by the Plaintiff are generally subject to the private insurance exemption and are *not* deductible.

A further nuance to consider is that many of these types of privately purchased policies may not be considered "indemnity" policies. By way of illustration, in *Jesperson v. Karas*,[8] the Plaintiff (a dentist) privately purchased two disability policies in after-tax dollars. Under each of the policies, the Plaintiff would be entitled to be certain benefits upon becoming totally disabled within the meaning of the respective policies. The Court concluded that the disability benefits were not deductible from the Plaintiff's income loss claim on the basis that they did not qualify as "indemnity payments". The Court stated[9]:

> I am of the view that the disability payments the Plaintiff received in the instant case must fall into the category of non-indemnity payments because the insurer was obligated to make the payments once they were satisfied Dr. Jesperson met the criteria of total disability under the policy. He was not required to prove as well that he had suffered a pecuniary loss as a result of the disability. Instead, once the disability test was met, the insurer was obligated to make the payments, which were not in any way tied to pecuniary losses actually sustained by Dr. Jesperson. He was not required to furnish proof of pecuniary losses sustained as a result of the

7 *Ibid*. at para. 66.

8 2019 ONSC 5841 (CanLII).

9 *Ibid*. at paras. 321, 324.

> total disability; rather, the policy amounts were payable once the insurer was satisfied the total disability test had been met.
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> …
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> My view that the RBC benefits are not indemnity payments is reinforced by other factors. There is no provision in the policy that requires the insured to disclose other payments received so that the insurer could claim a set off and perhaps re-calculate the amount owing to the insured. That is because the terms of the policy do not take into consideration whether in fact a monetary loss was sustained as a result of the disability. The simple occurrence of the event is sufficient to engage the payments under the policy. Similarly, the policy makes no reference to employment so being employed at the time of the total disability is not a requirement under the policy, nor is the insured required to remain unemployed in order to continue receiving the benefits.

iv. CPPD

It is important to highlight from the outset of this section that CPPD benefits are treated entirely differently in non-motor vehicle versus motor vehicle tort cases. In non-motor vehicle cases, the deductibility of CPPD is governed by the common law; in motor vehicle cases, the deductibility is governed by statute.[10]

At common law, CPPD benefits are *not* deductible from tort income loss claims.

The most recent Supreme Court authority for this proposition is the decision of *Sarvanis v. Canada*.[11] *Sarvanis* was not a decision specifically about the deductibility of collateral benefits from a tort award; however, in the context of that case, the Court re-iterated its stance on CPPD, stating:[12]

> … To look first at the CPP, the clear purpose of the CPP disability benefits is to supplement the incomes of disabled Canadians who have difficulty meeting day-to-day expenses because of their inability to work, that is, their status as disabled. For this reason, it has already been held by this Court that CPP disability payments are not to be considered indemnity payments, and therefore that they are not to be deducted from

10 R.S.O. 1990, c. I. 8 [the *Insurance Act*].

11 2002 SCC 28 (CanLII).

12 *Ibid*. at para. 33.

> tort damages compensating injuries that factually caused or contributed to the relevant disability. See *Canadian Pacific Ltd. v. Gill*, 1973 CanLII 2 (SCC), [1973] S.C.R. 654, at p. 670; *Cugliari*, supra. This rule is premised on the contractual or contributory nature of the CPP. Only contributors are eligible, at the outset, to receive benefits, provided that they then meet the requisite further conditions.

In practice, however, CPPD benefits will often be accounted for in any event where the Plaintiff is receiving LTD benefits. While the CPPD benefits may not be deductible from the tort claim, the Plaintiff's LTD benefit may be deductible and that LTD benefit may have already been reduced to account for the Plaintiff's receipt of CPPD. As such, any concern that the Plaintiff will be over-compensated is mitigated.

C. SUBROGATED CLAIMS

i. Collateral Benefit Insurers

Many disability and/or extended healthcare insurance policies include as a specific term that the insurer has the right to subrogate for the benefits paid to the Plaintiff/insured, if the Plaintiff advances a lawsuit against a tortfeasor arising from the incident giving rise to the disability.

As the Supreme Court of Canada stated in *Cunningham*: "Generally, subrogation has no relevance in a consideration of the deductibility of the disability benefits if they are found to be in the nature of insurance." In other words, whether or not a collateral benefits insurer wishes to advance a subrogated claim generally does not impact upon whether or not those benefits may also deductible from the tort award/settlement – deductibility and subrogation are separate issues.

While this issue is not likely to arise very often, there is an interesting exception to the right of a collateral benefits insurer to subrogate in a non-motor vehicle case. That exception occurs where the Defendant is also the named insured under the collateral benefits policy.

By way of illustration, this issue arose in a case of mine whereby I represent a Plaintiff who sustained injuries while participating in a staff appreciation day activity at work (this was not a WSIB case). I commenced an action against her employer ("Company X") for the injuries sustained by my client. As a result of those injuries, my client was receiving LTD benefits paid by "Insurer Y" under her group policy. The named insured under that group policy was my client's employer, Company X (i.e. the Defendant). Insurer Y sought to advance a subrogated claim in my client's action against Company X.

The Ontario Court of Appeal held in the case of *Rochon v. Rochon*[13] that there is a "fundamental notion that insurers should not be permitted to subrogate against their own insured" as "a suit by an insurer against its own insured does not fulfil the aims of subrogation, which is to avoid overpayment of the insured."[14] As such, the insurer ultimately relented and confirmed that it would not be advancing a subrogated claim in my client's action against its insured, Company X.

ii. OHIP

OHIP, or more specifically, the Minister of Finance of Ontario, also has a right of subrogation, which arises not from a contract or policy of insurance, but rather by statute.

Pursuant to section 30(1) of the *Health Insurance Act*:[15]

> Where, as the result of the negligence or other wrongful act or omission of another, an insured person suffers personal injuries for which he or she receives insured services under this Act, the Plan is subrogated to any right of the insured person to recover the cost incurred for past insured services and the cost that will probably be incurred for future insured services, and the General Manager may bring action in the name of the Plan or in the name of that person for the recovery of such costs.

Further, pursuant to section 31(1) of the *HIA*:

> Any person who commences an action to recover for loss or damages arising out of the negligence or other wrongful act of a third party, to which the injury or disability in respect of which insured services have

13 2015 ONCA 746 (CanLII).

14 *Ibid*. at para. 73.

15 R.S.O. 1990, c. H. 6 [the *HIA*].

> been provided is related **shall**, unless otherwise advised in writing by the General Manager, include a claim on behalf of the Plan for the cost of the insured services.

Lawyers ought to be aware of one exception to OHIP's statutory right to subrogate that can arise in non-MVC cases. That exception can arise where the Defendant is a tavern (i.e. a bar or restaurant) that is being sued for the over-service of alcohol. Whereas the claim against the tavern may not directly involve an MVC (typically, a driver and owner are named as Defendants in relation to the MVC that subsequently follows the over-service of alcohol), pursuant to section 30(5) of the *HIA*, OHIP is not subrogated "as against a person who is insured under a motor vehicle liability policy issued in Ontario, in respect of personal injuries arising directly or indirectly from the use or operation…of an automobile." It is not uncommon for taverns to be named insureds under an automobile policy. Where the tavern is insured under an automobile policy, OHIP would not have a right to subrogate against the tavern in this type of case.

The procedural requirements which must be followed by a personal injury lawyer in regard to giving notice to OHIP; engaging in settlement discussions; seeking solicitor-client costs from OHIP; and so forth, are addressed in section 39 of the *General* regulation under the *HIA*.[16]

iii. Note on Discounts & Fees Regarding Subrogated Claims

Since, absent a settlement, a subrogated claim would also have to proceed to trial, subrogated entities will typically discount their claims for liability/risk to the same extent that the Plaintiff's claims are being discounted. In other words, if a settlement is predicated on the notion that the Plaintiff was 25% contributorily negligence for the loss, then the subrogated claims are usually also reduced by 25%.

Similarly, since subrogated entities would have to retain their own counsel to advance their claim if the Plaintiff's lawyer was unwilling to do so, subrogated entities will also

16 O. Reg. 552.

generally pay a solicitor-client fee for the recovery of their subrogated interest. Depending upon the subrogated entity, those fees may be negotiable.

PART IV - MOTOR VEHICLE TORT CASES

A. INTRODUCTION TO THE STATUTORY SCHEME

i. Overview

In motor vehicle cases, the treatment of collateral benefits is predominantly governed by section 267.8 of the *Insurance Act* and the case law interpreting same. Section 267.8 of the *Insurance Act* addresses the value of past benefits received by the Plaintiff prior to trial (which, in practice, usually also means prior to settlement), which are to be deducted from the Plaintiff's award at trial; as well as the value of future benefits to be received by the Plaintiff after trial (or settlement), which are to be held in trust for the Defendant (i.e. assignments). Generally, tort awards for past/future income loss/loss of earning capacity, past/future healthcare expenses, and past/future other pecuniary losses may all be reduced by related collateral benefits received or to be received in future by the Plaintiff.

From the outset, there are two key nuances to note about collateral deductions and assignments pursuant to section 267.8 of the *Insurance Act*:

1. The division recognizes benefits the Plaintiff received prior to trial (i.e. prior to settlement) versus those the Plaintiff receives after trial (i.e. after settlement). The key words in this section are "received/receives", because the issue is when the payment is made to the Plaintiff, *not* whether the payment was to reflect past and/or future losses/expenses incurred by the Plaintiff. Where this nuance becomes important is when it comes to collateral benefit settlements/lump outs that the Plaintiff received prior to trial, even if those lump outs incorporated future losses to be incurred by the Plaintiff. As will be discussed below, lump outs received prior to trial (i.e. settlement) must be deducted as opposed to assigned.

2. When it comes to past benefits received by the Plaintiff, section 267.8 builds in the caveat "or that were available before the trial". This means that past benefits that the Plaintiff could have or should have received, *may* be imputed to the Plaintiff and deducted even if not actually received. This caveat makes some sense given a Plaintiff's duty to mitigate at common law. If the Plaintiff could have applied, for instance, for ABs, the receipt of which would have reduced the Defendant's tort exposure, but chose not to, then the value of those benefits may be deducted from the tort award the Plaintiff would have otherwise received.

ii. Deduction of Past Benefits Received

Each heading of tort damages is essentially reduced by similar/related past benefits received by the Plaintiff *prior to trial* or *that were available to the Plaintiff* prior to trial. Again, for negotiation purposes, assume that "trial" means "settlement".

Subsection 267.8(1) reduces tort awards for **past and future income loss/loss of earning capacity** by:

> 1. All payments in respect of the incident… that the plaintiff has received or that were available before the trial of the action for **statutory accident benefits** in respect of the income loss and loss of earning capacity.
>
> 2. All payments in respect of the incident that the plaintiff has received or that were available before the trial of the action for income loss or loss of earning capacity under the laws of any jurisdiction or under an **income continuation benefit plan.**
>
> 3. All payments in respect of the incident that the plaintiff has received before the trial of the action under a **sick leave plan** arising by reason of the plaintiff's occupation or employment.

Notably, in the case of *Walker v. Ritchie*,[17] the Ontario Court of Appeal held that non-earner benefits were *not* deductible from tort awards for income loss/loss of earning capacity under subsection 267.8(1).

17 2005 CanLII 13776 (ONCA) at paras. 79-81.

Subsection 267.8(4) reduces tort awards for **past and future healthcare** expenses by:

> 1. All payments in respect of the incident that the plaintiff has received or that were available before the trial of the action for **statutory accident benefits** in respect of the expenses for health care.
>
> 2. All payments in respect of the incident that the plaintiff has received before the trial of the action under any medical, surgical, dental, hospitalization, rehabilitation or **long-term care plan or law.**

Subsection 267.8(6) reduces damages for **pecuniary loss other** than income loss/loss of earning capacity/healthcare expenses by:

> …all payments in respect of the incident that the plaintiff has received or that were available before the trial of the action for **statutory accident benefits** in respect of pecuniary loss, other than income loss, loss of earning capacity and expenses for health care.

Other pecuniary losses under subsection 267.8(6) generally refer to tort claims for housekeeping and home maintenance, caregiver, or other out-of-pocket expenses incurred and would be reduced by similar/related AB benefits received (e.g. housekeeping, caregiver, visitor expenses, educational expenses, damaged clothing, and/or funeral expenses).

iii. Assignment of Future Collateral Benefits

While tort awards are not *reduced per se* by *future* benefits the Plaintiff receives after the trial of the tort action, the Plaintiff can be required to hold those future benefit payments in trust where the benefits are akin to a heading of damages awarded in tort. Specifically, the Plaintiff holds the benefit payments in trust for the Defendant and *may* ultimately have to assign those benefits to the Defendant.

The Plaintiff is, of course, not required to hold in trust for and/or to assign benefits received in future to any greater value than what the Defendant paid for that corresponding heading of damages. Similarly, the Plaintiff need not hold in trust for

and/or assign to any particular Defendant more than that Defendant's proportionate share of the award (or settlement) that was paid by that Defendant.

Subsection 267.8(9) provides that a Plaintiff who recovers damages for income loss, loss of earning capacity, past/future healthcare, or other pecuniary loss "shall" hold the following amounts in trust:

> 1. All payments in respect of the incident that the plaintiff receives after the trial of the action for **statutory accident benefits** in respect of **income loss or loss of earning capacity.**
>
> 2. All payments in respect of the incident that the plaintiff receives after the trial of the action for income loss or loss of earning capacity under the **laws of any jurisdiction or under an income continuation benefit plan.**
>
> 3. All payments in respect of the incident that the plaintiff receives after the trial of the action under a **sick leave plan** arising by reason of the plaintiff's occupation or employment.
>
> 4. All payments in respect of the incident that the plaintiff receives after the trial of the action for **statutory accident benefits** in respect of expenses for **health care**.
>
> 5. All payments in respect of the incident that the plaintiff receives after the trial of the action under any medical, surgical, dental, hospitalization, rehabilitation or **long-term care plan or law.**
>
> 6. All payments in respect of the incident that the plaintiff receives after the trial of the action for **statutory accident benefits** in respect of **pecuniary loss, other** than income loss, loss of earning capacity and expenses for health care.

Subsection 267.8(10) deals with the proportionality of the award paid by the Defendant and the value of the benefit payments that the Plaintiff must hold in trust for the Defendant. It provides:

> A plaintiff who holds money in trust under subsection (9) shall pay the money to the persons from whom damages were recovered in the action, in the proportions that those persons paid the damages.

Subsection 267.8(12) deals with when post-trial benefits to be held in trust by the Plaintiff must actually be paid, by way of an assignment, to a Defendant. It provides:

> The court that heard and determined the action for loss or damage from bodily injury or death arising directly or indirectly from the use or operation of the automobile, on motion, **may order** that, subject to any conditions the court considers just,
>
> (a) the plaintiff who recovered damages in the action assign to the defendants or the defendants' insurers all rights in respect of all payments to which the plaintiff who recovered damages is entitled in respect of the incident after the trial of the action,
>
> (i) for statutory accident benefits in respect of income loss or loss of earning capacity,
> (ii) for income loss or loss of earning capacity under the laws of any jurisdiction or under an income continuation benefit plan,
> (iii) under a sick leave plan arising by reason of the plaintiff's occupation or employment,
> (iv) for statutory accident benefits in respect of expenses for health care,
> (v) under any medical, surgical, dental, hospitalization, rehabilitation or long-term care plan or law, and
> (vi) for statutory accident benefits in respect of pecuniary loss, other than income loss, loss of earning capacity and expenses for health care; and
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> (b) the plaintiff who recovered damages in the action co-operate with the defendants or the defendants' insurers in any claim or proceeding brought by the defendants or the defendants' insurers in respect of a payment assigned pursuant to clause (a).

B. TREATMENT OF VARIOUS COLLATERAL BENEFITS

i. Accident Benefits

A string of decisions emanating from the Ontario Court of Appeal in the last five years or so clarified the way in which statutory accident benefits are to be treated in tort cases having regard to section 267.8 of the *Insurance Act*. Generally, the cases demonstrate a move *away* from: a) a strict "apples to apples" matching of the awards to payments to a more general approach referred to as "silos"; and b) a temporal component to the matching. These cases will be briefly summarized below.

In *Cobb v. Long Estate*,[18] the jury awarded the Plaintiff $50K for *past* income loss and $100K for *future* income loss. Prior to trial, the Plaintiff had received both income replacement benefits ("IRBs") on a weekly basis and had also lumped out her IRB claim on a "global" basis, meaning that the settlement did not distinguish between past and future IRBs. The trial judge deducted the entirety of the IRBs received by the Plaintiff from the entirety of the income loss award to the Plaintiff, which resulted in a net tort payment of $0 to the Plaintiff for that heading of damages. The Plaintiff appealed on the basis that the IRB settlement was, in part, for future IRBs such that it should not have been fully deducted from the award at trial. The decision was upheld by the Ontario Court of Appeal, who stated:[19]

> The legislation (s. 267.8(1)) does not distinguish between amounts that relate to past and to future income loss. It speaks only to amounts received prior to the trial for income loss. Whether those amounts relate to past or future claims is irrelevant for the purpose of deductibility.
> …
> Since the purpose of the statutory deduction procedure is to prevent double recovery for a single loss, there is no reason in principle to distinguish between pre-trial and post-trial "income loss and loss of income capacity" when deducting SABs from damages.
> …
> Additionally, as is more fully explained in the reasons for judgment in the *El-Khodr* case, I have serious reservations as to whether the strict matching requirement articulated in *Bannon v. McNeely* (1998), 1998 CanLII 4486 (ON CA), 38 O.R. (3d) 659 (C.A.) and *Gilbert v. South*, 2015 ONCA 712, 127 O.R. (3d) 526, the cases referenced by Lauwers J.A. in *Basandra*, remains good law in this province…
>
> …s. 267.8(1) of the Insurance Act **requires deduction of all income replacement SABs**, and all payments in settlement of claims for income replacement SABs, that the plaintiff **receives before trial from the total of all damages awarded** at trial for past and future income loss arising from the same incident.

In *El-Khodr v. Lackie*,[20] the jury awarded the Plaintiff global amounts for "future professional services" and "future medication and assistive devices." The trial judge concluded that without a particularized breakdown [e.g. whether professional services

18 2017 ONCA 717 (CanLII) [*Cobb*].

19 *Ibid*. at paras. 48, 52, 52, 54.

were for physiotherapy (akin to med/rehab benefits) or for personal support worker services (akin to attendant care benefits)] no assignment could be made to the Defendant for the Plaintiff's future receipt of accident benefits as it could not be determined which benefits ought to be assigned. The appeal was granted by the Ontario Court of Appeal, who stated:[21]

> In my view, strict **qualitative and temporal matching** requirements **should not be applied** to s. 267.8 for two chief reasons: (a) the policy rationale underlying *Bannon* is not relevant to the current statutory scheme; and (b) *Bannon* may no longer be good law in this province.[3] Like the approach that this court adopted with respect to the deductibility of pre-trial benefits in *Basandra v. Sforza*, 2016 ONCA 251, 130 O.R. (3d) 466, and which is the subject of the appeal in the *Cobb* case, the assignment and trust provisions of the *Insurance Act* require the court to match benefits that will be received after trial to the broad, enumerated statutory categories only in a general way.

In *El-Khodr*, the Court of Appeal also provided guidance to Plaintiffs regarding how their cases should be presented and the questions that ought to be posed to the jury. The Court stated:[22]

> Future plaintiffs in motor vehicle accident cases should minimize trial courts' difficulty in matching damages and statutory benefits by presenting their claims according to the categories in s. 267.8 of the Insurance Act: they should make a claim for past and future income losses, a claim for past and future health care expenses; a claim for other past and future pecuniary losses that have SABs coverage; and a separate claim for any past and future pecuniary losses that lack SABs coverage. In cases involving non-catastrophic injuries, the presentation of the claim should account for the monetary limits and temporal limitations on benefits compensating for such injuries.
>
> Plaintiffs should be required to present their cases in this way. They alone know best what amounts they have expended in relation to their injuries that their SABs insurer did not or will not reimburse. If those items are separately categorized, the matching difficulties disappear – as does any risk of over or under-compensation.

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20 2017 ONCA 716 (CanLII) [*El-Khodr*].

21 *Ibid*. at para. 35.

22 *Ibid*. at paras. 84-85.

In *Cadieux v. Cloutier*,[23] the Plaintiff settled his AB claim prior to his tort action. When addressing the issue of deductibility of the Plaintiff's AB settlement, the judge rejected the "strict matching" approach in favour of a "silo" approach, which required that the tort award only match generally with the broad corresponding AB categories or silos. The appeal was granted only in part (on other issues). The Court of Appeal essentially agreed with the trial judge's approach on the issue of "strict matching" versus "silos" and stated:[24]

> For the reasons that follow in this case, and in Carroll, we affirm the silo approach to both deductibility and assignment of SABs set out at paras. 38-56 of Cobb and at paras. 33-72 of El-Khodr.
> …
> There are three broad categories of SABs under the Insurance Act and the Statutory Accident Benefits Schedule, O. Reg. 34/10. These were referred to in El-Khodr as silos. The first category provides income replacement benefits or, if the person was not employed at the time of the accident, "non-earner" benefits, or "caregiver benefits", if they provided caregiver services to another person at the time of the accident.
>
> The second category is health care benefits. "Health care" is a defined term in s. 224(1) of the Insurance Act. It "includes all goods and services for which payment is provided by the medical, rehabilitation and attendant care benefits provided for in the Statutory Accident Benefits Schedule". The Statutory Accident Benefits Schedule sets out in detail the available health care benefits. Health care expenses include medical, rehabilitation and attendant care benefits, goods and services of a medical nature, rehabilitation expenses and services provided by an attendant or by a long-term care facility, nursing home, home for the aged, or chronic care hospital.
>
> The third category of benefits addresses "other pecuniary loss", which includes lost educational benefits, expenses of visitors and housekeeping, and home maintenance expenses.
> …
> First, as a matter of statutory interpretation, s. 267.8(1), (4) and (6) require the deduction of SABs received prior to trial from damages received in a tort action on a silo basis. That is, SABs for income loss are to be deducted from the tort award for income loss (s. 267.8(1)); SABs for health care expenses are to be deducted from the tort award for health care (s. 267.8(4)); and SABs for other pecuniary loss are to be deducted from

23 2018 ONCA 903 (CanLII); leave to appeal to SCC ref'd [2019] S.C.C.A. No. 63 [*Cadieux*].

24 *Ibid*. at paras. 8, 12-14, 22, 92, 94.

> the tort award for other pecuniary loss (s. 267.8(6)). There is no reasonable interpretation of the legislation, in our view, that permits either a more generalized approach to deduction (that is, a deduction of SABs in one silo from a jury award for damages falling within another silo) or a more particularized approach to deduction (that is, the deduction of particular SABs within a silo only from damages for the identical head of damage awarded by the jury within the same silo).
> …
> With respect to the assignment and trust provisions of the statute, as more fully explained in our reasons in Carroll, we see no principled basis on which to apply different approaches to SABs received before and after trial.
> …
> For the reasons expressed by MacFarland J.A. in Cobb, at paras. 38-56, pursuant to s. 267.8(1), (4) and (6), SABs that were received or were available to the plaintiff prior to judgment must be applied to the jury award in respect of both past and future losses. That is, **damages awarded for past and future losses are to be aggregated in each silo before the SABs applicable to that silo are deducted.**

Given that AB payments are to be deducted on a "silo" basis, without any regard to whether payments were made for past or future receipt of benefits by the Plaintiff, the Court provided guidance on how tort claims should be presented:[25]

> Claims should therefore be **presented on a "gross" basis**, rather than net of SABs. We see nothing unusual or complicated in this approach. It is done as a matter of course in other forms of litigation where a plaintiff brings suit for both insured (subrogated) and uninsured (unsubrogated) claims. It is also commonplace that plaintiffs in personal injury actions will provide proof of underlying goods and services that have already been consumed as a result of their injuries, in order to demonstrate the severity of their injuries and their ongoing need for such expenses. This information will be readily available to counsel, and proof of the expenditures should be uncontroversial. The SABs paid will be a matter of record and can be readily established.
>
> Any concerns as to trial efficiency can and should be dealt with through appropriate trial management and the co-operation of counsel. It seems to us that in most cases, the manner in which the **jury questions** are structured should be **based on the silos**…

25 *Ibid*. at paras. 89-90.

In *Carroll v. McEwan*,[26] the jury awarded a global amount to the Plaintiff for "future care costs". The trial judge ordered that the Defendants be assigned the Plaintiff's future catastrophic benefits. The Ontario Court of Appeal upheld the trial judge's approach and stated:[27]

> … The silo approach is to be applied to s. 267.8 as a whole.
>
> …The current statutory trust and assignment provisions make it unnecessary to require strict proof of entitlement to future benefits. They pass no risk of under-compensation to a plaintiff. The benefits are assigned or held in trust as and when they are received until such time as the defendant or its insurer has been reimbursed for payments made under the judgment in respect of the particular "silo".

ii. LTD Benefits

In *Nemchin v. Green*,[28] the Ontario Court of Appeal dealt with the assignment of LTD benefits and whether those benefits ought to be assigned on a gross or net of taxes basis. It can be taken from this case that LTD benefits are to be assigned to the Defendant (or factored into settlement negotiations) based upon the amount received by the Plaintiff, whether that amount be gross or net of taxes.

At trial, the Plaintiff was awarded an amount for future income loss, without any specificity as to how many years of loss that figure was meant to reflect. The Plaintiff was in receipt of LTD benefits through a group policy with Sunlife. Her LTD benefits were taxed at source by Sunlife, but she received a T4 reflecting the gross LTD payments. After trial, the Defendant brought a motion for the assignment of the Plaintiff's future benefits, which the trial judge granted on a gross, rather than net basis (in other words, the Plaintiff actually had to "top up" the benefits to account for the taxes that the insurer was withholding when paying her the benefits). The appeal was granted by the Ontario Court of Appeal, who stated:[29]

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26 2018 ONCA 902 (CanLII) [*Carroll*].

27 *Ibid*. at paras. 37-38.

28 2021 ONCA 238 (CanLII).

29 *Ibid*. at paras. 26, 29, 39.

> The trust property in the present case consisted of the net after-tax payments that the appellant received pre-assignment from Sun Life from the date of the judgment in the amount of $104,162.34. The appellant, as trustee, was only required to hold in trust and then pay to the respondent's insurer these actual payments from Sun Life, which were net of tax…
>
> …
>
> In my view, the language of s. 267.8(12) does no more than clarify the mechanism of the assignment of the appellant's rights to the payments within the scheme of s. 267.8. This means that by virtue and for the term of the assignment, the respondent's insurer has all the appellant's rights and is subject to all the provisions under the plan, including, subject to the plan[2], the ability to deal directly with Sun Life and to contest the deduction of income taxes from the payments. But, while s. 267.8(12)(a) refers to "all rights in respect of all payments to which the plaintiff who recovered damages is entitled" rather than "payments received by the plaintiff", as was the case in *Bapoo*, it does not entitle the respondent's insurer to receive payments greater than those the appellant receives. Subsection 267.8(12) does not refer to payments "received", because the focus of this provision is not on the entitlement to payments, but rather on the broader entitlement to the plaintiff's underlying rights, which includes a right to payment, among others.
>
> …
>
> The respondent obtained an assignment to its insurer of the appellant's rights to future collateral benefits under the Sun Life plan from the date of judgment. If it disputes the deduction of income tax at source, then the respondent's insurer, having stepped into the appellant's shoes through the assignment, must take the necessary steps and incur the necessary expense to deal with that issue. For the term of the assignment, the appellant has assigned her rights with respect to those payments. While s. 267.8(12)(b) of the *Insurance Act* requires her to cooperate with the respondent's insurer, it is the respondent's insurer, as assignee, that must direct what is to be done in relation to the plan benefits.

iii. Note on Settlement Deductions Gross vs. Net of Legal Fees

Although a Plaintiff's *net* recovery from collateral benefits settlement may be less than the *gross* amount of the settlement due to a solicitor-client account having been rendered to the Plaintiff in respect of that settlement, it is still generally the *gross* settlement amount that is deducted from the tort award (or, for purposes of this paper, to be deducted from a tort settlement).[30]

30 *Siddiqui v. Siddiqui*, 2015 ONSC 6260 (CanLII) [*Siddiqui*] at paras, 125, 128; *Cadieux*, supra note 23 at para. 56.

With that said, depending upon the circumstances, it may be appropriate to award the Plaintiff the costs (legal fees and disbursements) of pursuing the AB claims as part of the tort action (or to advance a claim for such costs as part of the tort negotiations).[31] The Court has jurisdiction under section 131(1) of the *Courts of Justice Act*[32] to award "costs of and incidental to a proceeding."

iv. CPP Disability Benefits

For accidents occurring on or after September 1, 2010, CPPD benefits are explicitly deductible from tort awards.

Amendments were made to the *Insurance Act* for this purpose by virtue of section 5.2 of the *Court Proceedings for Automobile Accidents that Occur on or after November 1, 1996*.[33] In regards to accidents occurring on or after September 1, 2010, section 5.2(2) of the *CPAA* states:

> For the purposes of paragraph 2 of subsection 267.8 (1), paragraph 2 of subsection 267.8 (9) and subclause 267.8 (12) (a) (ii) of the Act, payments in respect of an incident for income loss or loss of earning capacity under an income continuation benefit plan are deemed to include, if the incident occurs on or after September 1, 2010, the payments for loss of income under an income continuation benefit plan described in clause 3 (7) (d) of Ontario Regulation 34/10 (Statutory Accident Benefits Schedule — Effective September 1, 2010), made under the Act.

Section 3(7)(d)(i) of O. Reg. 34/10 explicitly deems "payments of disability pension benefits under the Canada Pension Plan" to be "payments for loss of income under an income continuation benefit plan."

31 *Siddiqui*, supra note 30 at para. 129; *Cadieux*, supra note 26 at para. 56.

32 R.S.O. 1990, c. C. 43.

33 O. Reg. 461/96.

C. SUBROGATED CLAIMS

i. Collateral Benefit Insurers

Whereas at common law, collateral benefit payors (e.g. LTD and/or extended health care insurers) may have a right to subrogate against a tort Defendant, subsection 267.8(17) of the *Insurance Act* extinguishes the right to subrogate in motor vehicle cases. Subsection (17) provides that "any person who has made a payment described in subsection (1), (4) or (6) is not subrogated to a right of recovery of the insured against another person in respect of that payment. Recall that subsection (1), (4), and (6) of section 267.8 of the *Insurance Act* dealt with payments made to the Plaintiff for benefits relating to income loss/loss of earning capacity, healthcare expenses, and other pecuniary losses.

ii. OHIP

Similarly, as noted earlier, the *Health Insurance Act* specifically carves out an exception to OHIP's entitlement to subrogate in a motor vehicle case. Pursuant to section 30(4) of the *Health Insurance Act*, OHIP does not have a subrogated claim in respect of personal injuries "arising directly or indirectly from the use or operation….of an automobile…"

PART V – ACCIDENT BENEFIT CASES

i. Overview

The treatment of collateral benefits when it comes to trial awards or settlements for AB cases is governed by the *SABS* and case law interpreting same. This paper will focus on potential collateral benefit deductions from IRB claims, as this is an issue that often comes up.

Section 7(1) of the *SABS* sets out how IRB are to be calculated and specifically provides for a deduction for "all other income replacement assistance" received by the Plaintiff for a particular week that a benefit is payable. The term "other income replacement benefit" is defined in section 4(1) of the *SABS* as: "the amount of any gross weekly *payment for loss of income* that is received by or available to the person as a result of the accident

under the laws of any jurisdiction or under any income continuation benefit plan", subject to some exclusions [*emphasis added*].

Note that as with the tort-related *Insurance Act* principles, collateral benefits may be imputed to the insured for purposes of reducing the IRB claim even where those benefits were not received by the insured.

ii. LTD Benefits & Settlements

With respect to LTD benefits, in the case of *G.K. v. Unifund Assurance Company*,[34] the LAT held that LTD benefits are to be deducted from IRBs on a gross, rather than net of tax basis. This principle was recently re-affirmed in *Schuknecht v. Economical Insurance Company*.[35]

In the case of *Co-Operators General Insurance Company v. Branden*,[36] the Divisional Court addressed how LTD settlements are to be treated. The Court held that in that case that the insured's IRBs could not be reduced by the amount of an LTD settlement, where it was unclear what portion of the settlement was for actual LTD benefits as opposed to other damages.

The Plaintiff had applied for and received IRBs. At the same time, she also applied for LTD benefits and a dispute over the LTD benefits ensued. The Plaintiff sued her LTD carrier for the LTD benefits owing, as well as for aggravated, exemplary, and punitive damages. The LTD dispute settled, after which the AB carrier re-calculated the Plaintiff's IRBs taking into account the full value of her LTD settlement. The insured successfully applied to the LAT, which Tribunal found that the LTD settlement had not been shown to be accounted for as "compensation for loss of income" as it was a compromise and specifically included "all claims for extracontractual damages" sought in the action. The Divisional Court dismissed the appeal, stating:[37]

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34 2017 CanLII 85688 (ONLAT).

35 2022 CanLII 68237 at para. 23. (ONLAT) [*Schuknecht*].

36 2022 ONSC 2473 (CanLII).

37 *Ibid*. at para. 39.

> The calculation of income replacement benefits pursuant to s. 7(1) of SABS specifically sets out that the amount deducted is only "the amount of any gross weekly payment for loss of income that is received by or available to the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan" and is only to be applied to the "particular week" the benefit is payable. The adjudicator found that the LTD settlement between Patricia Branden and Empire did not provide appropriate details to allow Co-Operators to deduct the settlement from her past IRB calculation because the settlement was not confined to payment for her LTD claims alone.

iii. CPPD

Like the *Insurance Act*, subsection 3(7)(d)(i) of the *SABS* deems the term "payments for loss of income under an income continuation benefit plan" to include CPPD benefits, such that CPPD benefits are deductible from IRBs.

iv. Note on Deductibility of LTD & CPPD Post-Age 65

Section 8(1) of the *SABS* addresses the adjustment of the IRB after an insured reaches the age of 65. It provides for a change in the ramp-down formula used to calculate the IRB, which ramp-down formula is based upon the "income replacement benefit that the person was entitled to receive immediately before the adjustment."

In *Schuknecht*,[38] the LAT considered the meaning of the term "entitled to receive immediately before the adjustment" having regard to the fact that the insured's IRBs had, to that point, been reduced by the insured's receipt of LTD and CPPD benefits, which benefits were to terminate effective her 65th birthday. The LAT held that post-age 65 IRBs are to be calculated using the ramp-down formula assuming an IRB payment initially before the adjustment that does not take into account LTD and/or CPPD benefits. The Adjudicator's rationale was:[39]

> The [insured] submits this interpretation of the Schedule is incorrect, as it would leave the applicant under-compensated, as the collateral benefits

38 *Supra*, note 35.

39 *Ibid*. at paras. 33-34.

> would cease and her entitlement to IRB would revert back to $400.00 per week on her 65th birthday. This quantum of $400.00 would then be ramped down after age 65 as per the formula in s. 8(1). I agree with this interpretation of the Schedule.
>
> The [insurer's] interpretation is contrary to the consumer protection mandate of the Schedule. It would lead to an absurdity by penalizing the applicant for having the foresight to obtain or apply for collateral benefits. This would indeed leave the applicant in a worse position after age 65, than if she had not obtained any collateral benefits. The applicant is catastrophically impaired, and this interpretation of the Schedule would deny her any IRB after age 65.

v. Canadian Emergency Response Benefit ("CERB")

A recent "hot topic" is the CERB and its relevance to the calculation of IRBs.

In the case of *Foster v. Aviva Gen. Ins. Co.*,[40] the Vice Chair of the LAT granted a request for reconsideration of an Adjudicator's finding that the insurer was entitled to deduct from the insured's IRB the CERB payments received by the insured for the corresponding weeks. The Vice Chair held that CERB payments are *not* deductible from IRBs, stating:[41]

> …Whereas IRBs are directly connected to, and calculated with respect to, an insured's pre-accident earnings, CERB is not calculated with reference to income from employment. Indeed, everyone who is eligible receives the same amount without reference to the amount of income they earned pre-pandemic. As CRB/CERB eligibility is not tied to employment status, it follows that it cannot be considered "gross employment income" under s. 4(1) because it is not analogous to "salary, wages and other remuneration from employment", as the adjudicator determined. In turn, as CRB/CERB is not considered "gross employment income", it cannot be deducted from an IRB under s. 7(3)(a).

While this ruling is helpful to Plaintiff/insured's counsel when negotiating IRB lump-outs, it can also prove to be unhelpful. Using the same logic, the CERB cannot likely be used as pre-accident employment income for purposes of determining initial entitlement to IRBs.

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40 2021 CanLII 1117413 (ONLAT).

41 *Ibid*. at para. 10.

PART VI - PRACTICAL TIPS

In advance of any settlement negotiations, and often as early as the outset of the case, personal injury lawyers may wish to consider the following practical tips:

- **In non-motor vehicle cases, get instructions from potential subrogated entities** – If you know that your client has received medical care in Ontario (i.e. paid by OHIP) or has received collateral benefits from an insurer of some kind, you ought to write to the potential subrogated entity to advise that a tort claim is being advanced and to obtain instructions regarding any *past or future* subrogated claim that the provider wishes to advance.

- **In non-motor vehicle cases, find out who paid the collateral benefits premium** – If your client is receiving collateral benefits under a group/employer policy, make sure you confirm who pays the premium for those benefits and, if shared, the exact split between employer and employee. Those answers can be obtained by asking the client, writing to the employer, writing to the collateral carrier, reviewing the employment contract, and/or reviewing pay stubs/payroll records.

- **In non-motor vehicle cases with unionized Plaintiffs, consider the collective bargaining** – If your client is a member of a union who appears to have 100% employer-paid premiums, you may wish to ask the client or the client's union representative/advocate for some information about the collective bargaining to determine if you may be able to establish evidence of a trade off or wage loss in exchange for the benefits. Admittedly, this may be a "wild goose chase", so one would want to consider a cost-benefit analysis before undertaking this kind of investigation (i.e. think about how much the offset may actually be worth).

- **In tavern liability cases, find out if the tavern has an automobile policy** – This issue often comes up in tavern liability cases, whereby the Plaintiff was injured as a result of a motor vehicle crash in which the driver had been over-served alcohol at a commercial tavern. If that tavern is insured under an automobile policy, as

some taverns are (for deliveries, catering, etc.), the existence of such a policy would eliminate OHIP's right to subrogate against the tavern (even though the claim against the tavern is technically a non-motor vehicle case).

- **Do the math, especially when it comes to disability benefits** – Defendant insurers often have a Pavlovian response to a Plaintiff's income loss claim: the Plaintiff can work or will return to work at some point in future. What some Defendants do not realize is that taking that approach (rather than accepting that the Plaintiff has nil residual earning capacity) may result in a greater income loss payment in tort. Mathematically, it often turns out that an income loss based upon a *100% loss of full-time employment*, but subject to a deduction/credit/assignment for future collateral benefits (even if something less than a 100% deduction is given to account for risk), results in the Defendant having to pay the Plaintiff *less* by way of a future income loss claim than if it were assumed that the Plaintiff will return to *part-time employment or employment in a different career*. The reason being that in cases where the Plaintiff returns to some form of employment, entitlement to income replacement benefits ("IRBs"), LTD benefits, and/or CPPD will often be terminated and the Defendant will lose the benefit of what may be a significant offset.

- **When lumping out IRBs, don't forget post-age 65 entitlement** – Your client may not be receiving an IRB at all if LTD and/or CPPD benefits have served to wipe out the loss; however, that does not mean that there will not be entitlement after age 65 (modest as it may be).

- **Remember that with settlement negotiations, anything goes** – Negotiations need not adhere to the strict rules of Court. This means, for instance, that if it is easier for all to apply the "old" (i.e. pre-*Cadieux*) "apples to apples, temporal matching" approach to collateral deductions rather than the "silo" approach, so be it. It also means that Defendants/insurers will also often want to negotiate some type of credit for future collateral benefits likely to be received by the

Plaintiff/insured, as opposed to any Minutes of Settlement incorporating trust and assignment provisions.

- If offering a credit/deduction in negotiations for the value of future collateral benefits to be received by the Plaintiff/insured, factor in risk (e.g. risk that the Plaintiff may never be declared CAT, risk that the Plaintiff's LTD insurer may terminate benefits, etc.).

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