Our ref: InjuryComp:GUml1193514

23 August 2016

The Hon John Della Bosca and
Ms Nancy Milne
CTP Reform Reference Panel
C/O Christian Fanker
Director, CTP Reform
State Insurance Regulatory Authority
Level 25, 580 George Street
Sydney NSW 2000

By email: christian.fanker@sira.nsw.gov.au

Dear Mr Della Bosca and Ms Milne,

NSW CTP insurance scheme reform

We write on behalf of the legal professional organisations represented at the working group discussions with you, namely the Law Society of NSW, the NSW Bar Association and the NSW Branch of the Australian Lawyers Alliance ("ALA").

We are pleased that the CTP Reform Reference Panel ("Reference Panel") has engaged in considered and constructive consultation during a number of meetings with our representatives.

This submission provides further detail to the scheme design proposals in our joint submission dated 29 July 2016 and elaborates on issues discussed at the last Reference Panel meeting on 9 August 2016. It also responds to the Reference Panel questions forwarded by SIRA on 12 August 2016.

However, we reiterate that we remain strongly opposed for a number of reasons to the replacement of the current fair scheme with the Government's proposed degraded workers compensation-style model. The Government's model is particularly unfair to accident victims with medium severity injuries who are not at fault. We note that the cohort in society who may benefit most from any reduction in CTP insurance premium will be most adversely affected by the proposed reductions in benefits available.

1. Alternate scheme proposal

As discussed in our submission of 29 July 2016, we suggest a three-part scheme structure involving:

a) 12 or 18 months of no fault ("defined") benefits for everyone;

b) Modified common law benefits extending to those who can prove fault and are under the existing whole person impairment ("WPI") threshold for non-economic loss damages;

c) Modified common law benefits extending to those who can prove fault and meet the existing WPI threshold for non-economic loss damages.

1.1 No fault defined benefits

We support the provision of no fault defined benefits for a 12 or 18 month period. The period chosen can be adjusted to meet scheme affordability and fairness.

We reject the Government's 'straw man' defined benefits structure for the following reasons:

- The scheme is a long tail scheme.
- There is no opportunity to obtain paid legal advice as to the extent of entitlements.
- There is no opportunity for a claimant to realise their future entitlements in the form of a lump sum settlement or 'commutation'. Claimants will remain on the 'drip feed' for as long as they are permitted by the benefits regime. Lifetime dependency is bad for mental health and 'return to work' outcomes.
- The reliance upon Guidelines to dictate practice with respect to benefits is fraught with difficulty in that Guidelines are not enforceable.
- At fault drivers should not receive benefits at the expense of the innocent victims of their poor driving.

Income benefits

- The period of defined benefits is far too long to encourage 'early rehabilitation and return to work'
- The adoption of the current NSW Workers compensation weekly benefits model (with incremental step downs based on a capped maximum of $2,042 Gross per week) is unfair and misconceived:
  - The weekly payment will never be true or full income replacement because it is predicated on the first 13 weeks of payments being at a rate of 95% of capped maximum or average weekly earnings, whichever is the lower.
  - The capped maximum is not representative of the average weekly earnings (including overtime, bonuses, shift allowances and penalties) of the average CTP claimant.
  - The step downs cannot be said to encourage early return to work in an environment where the employer is neither a stakeholder, customer, consumer or participant in the scheme. The CTP scheme is not analogous to workers compensation nor could it be said that the objective will be met by adopting such a model of benefits.

- Non-earners who may have secured imminent employment or who post-injury obtain employment conceivably miss out. Consider students over the age of 18 completing their education, mothers returning to the work force etc.
- Work capacity is determined by the insurer 'at any time' under an unfair subjective test that will drive insurers to cut claimants off benefits many times over the life of their defined benefits claim. Work capacity assessments and decisions are two of the worst aspects of the NSW workers compensation scheme, creative of much friction, lack of transparency and workers abandoning their entitlements through lack of proper and appropriate legal representation and/or disillusionment at the prospect of such a dysfunctional and unfair dispute resolution process.

Treatment, rehabilitation and care benefits

- The Government's model relies on an impairment evaluation of greater than 10% to permit more than 2 years treatment. Reliance on an impairment evaluation to determine medical treatment and commercial care needs is in effect 'putting the cart before the horse'. Even moderate injuries may take many years to stabilise, particularly those where clinical practice dictates a conservative approach prior to invasive surgery (for example, knee injuries, spinal injuries, shoulder injuries). With many injuries, surgical treatment will necessarily increase the resultant impairment.
- The experience with NSW workers compensation is that scheme agents (not private insurers) routinely delay access to medical treatment and create disputes merely by being required to pre-approve medical treatment. The straw man borrows heavily from NSW workers compensation. If pre-approval becomes a mandatory aspect of the scheme, together with a provision not unlike section 59A of the *Workers Compensation Act 1987* there will be numerous disputes over treatment expenses. Further, this level of control over the claimant will serve to foster the same culture of arrogance on the part of insurers which has become part and parcel of the new workers compensation system.
- The problems attendant upon the NSW workers compensation scheme are not alleviated by permitting insurers to enter into an arrangement for provision of treatment and care with a third part agency eg iCare. On this point there appears to be consensus with the insurers.

1.2 Medium severity injury, loss past 12 or 18 months, can prove fault

Claimants in this category would have to establish negligence and be below the threshold for non-economic loss damages (currently >10% WPI based on AMA4 Guides and MAA Medical Guidelines).

Such claimants would have to satisfy a "narrative test" which includes objective evidence of physical or psychological injury.

We suggest a narrative test which does not rely upon a number but does have elements similar to the French test of Physical and Psychological injuries (Atteinte a l'integrete Physique et Psychique – AIPP) which includes these features;

A permanent reduction in physical, psychosensory or intellectual potential that is the result of an anatomo-physiological injury:

- that can be detected medically and can therefore be assessed on the basis of appropriate clinical testing, supplemented by a study of additional tests furnished; (eg MRI, x-ray, CT scan, etc); and

- that is compounded by pain phenomena and psychological impacts or ordinarily associated with the sequelae described, as well as consequences in everyday life that are customarily and objectively associated with such injury.

We suggest that the injury must be assessed by a medical specialist in current clinical practice (not a general practitioner).

Satisfaction of the narrative test gives entry to first tier modified common law, the features of which are:

- Compensation for future loss of earnings
- Compensation for out of pocket medical and treatment expenses including future expenses
- Compensation for future commercially provided care

There would be no benefits for non-economic loss and no means of 'creep' into the second tier of common law.

Compensation for future loss of earnings would encompass the losses that the victim sustains due to:

- his/her reduced value in the employment market;
- loss of professional opportunities;
- increased hardship in performing his/her job;
- having to abandon the profession he/she practised before the injury and seek another profession due to his/her disability.

Economic loss should be assessed by reference to pre-injury earnings.

Under the legal profession model, unlike the ICA proposal, there would be no need to differentiate between minor, medium or serious injuries within the defined benefits part of the scheme. This is because all injured persons (regardless of fault) would be able to access the same defined benefits to cover weekly entitlements and reasonable and necessary medical treatment expenses for a maximum period of 12 or 18 months. Accordingly, there would be no need for a fairness test or an exceptional circumstances test within our defined benefits model.

We have some concerns regarding the fairness test proposed in the Finity Report with respect to common law entitlements which is based solely on whether the claimant reaches a 6% impairment threshold. As previously stated the use of whole person impairment as a rationing mechanism for common law has multiple drawbacks including increased disputation over the WPI assessment and, more importantly, unfairness. We repeat that impairment under the Fourth Edition of the AMA Guides was never intended to measure a person's earning capacity. A person with a whole person impairment rating of well below 6% may still have a significant restriction on his or her earning capacity depending on his or her particular circumstances. Impairment is now an outdated tool for assessing entitlement to damages given that it is based on a medical model of disability rather than the psychosocial model that is now more favoured by bodies such as the World Health Organisation (the International Classification for Functioning, Disability and Health) and the NDIS. The problem with the medical model is that it simply does not take into account the claimant's individual circumstances and environmental factors which are well recognised to have a significant impact on a person's level of functioning in all aspects of society (including employment).

1.3 Modified common law damages, meet WPI threshold, can prove fault

The current range of common law benefits should remain for those who meet the WPI threshold (with the exception of gratuitous care, where there is no consensus). The current greater than 10% WPI threshold to access non-economic loss has proven to be a satisfactory and sufficient limiting mechanism, with the percentage of qualifying accident victims remaining stable for many years. There is no evidence to suggest that excess damages are being paid out for this category of benefits or that legal costs in this category of benefits are impacting on scheme affordability. We understand that there is general support by all stakeholders and Government for this category of benefits to be left undisturbed.

2. Dispute Resolution

2.1 The ICA's model for dispute resolution

The legal profession rejects the ICA proposal for a dispute resolution model which dismantles the current Claims Assessment and Review Service ("CARS"), retains the Medical Assessment Service ("MAS") with significantly enhanced powers and creates a new claims assessment service, Motor Accidents Resolution Service ("MARS").

Both stages 1 and 2 of the internal review proposed by the ICA are modelled on Chapter 10 of the General Insurance Code of Practice (Insurance Council of Australia 1 July 2014). These are processes designed to deal with complaints about "*any aspect of your relationship*" with an insurer in the conduct in the management of a retail insurance claim. The process does not reasonably lend itself to resolution of disputes about provision of benefits for personal injury under a compulsory third party policy where benefits are assigned by a statutory regime.

In defined benefits claims where there is no dispute over fault, insurers should manage claims without the need for two internal review touch points. Experience of the work capacity decision process in the workers compensation system since 2012 teaches us how readily injured persons become disillusioned by a system which requires too many unnecessary dispute gateways to be crossed before the real decision is made.

The legislation should make it clear that defined benefits must be commenced within a defined period after the notification of a claim. The ICA model does not reference any timeframes for the making of claims or access to benefits.

Disputes concerning benefits are not similar to customer complaints. The dispute resolution model should be designed to ensure swift and immediate benefits to claimants in all but exceptional circumstances where there is a legitimate dispute within the confines of the legislation. Claims officers should be educated and sufficiently capable to make decisions with or without the input of 'technical experts' or 'claims managers' without the need for a defined second tier internal dispute. Peer review should occur as a matter of course, not in response to a dispute notification. Internal reviews (and reviews to a division of SIRA) do not satisfy the necessary requirements of impartiality, independence and integrity.

We reject the need to start again and 'subsume' the functions of MAS and CARS in a new functionary, MARS. We reject the introduction of MARS "advocates" to assist the claimant and also to make recommendations to insurers. The position of such advocates would be hopelessly conflicted. Lawyers with expertise in motor vehicle disputes and who are subject to regulation by professional bodies should be able to assist claimants where necessary. The Government's proposal acknowledges that reference has been made particularly to the

Victorian Transport Accident Scheme. However, the Victorian Scheme's dispute resolution model includes a pivotal role for claimants' lawyers.

A dispute resolution model that has the complexities of the ICA proposal with no scope for paid legal representation is unfair and unduly weighted in favour of the insurers. Access to justice is a fundamental human right. A dispute resolution system does not fulfil its function unless it is accessible by those affected by the dispute and unless the users receive the help they need to prepare and present their position. By way of example, few, if any, claimants would know how to obtain an appropriate medical report or present their position with respect to a work capacity decision.

2.2 Legal profession model for dispute resolution

The legal profession dispute resolution model is detailed in the attached diagrams as follows:

1. Diagram 1: Defined benefits;

2. Diagram 2: Common law benefits

In the defined benefits category, an early determination of provisional liability facilitating payments for treatment and economic loss to injured persons is of paramount importance. We see limited scope for disputation of liability or benefits in this category having regard to the at-fault entitlement and short duration during which these payments will be made.

The legal profession has acknowledged a need for limited legal representation within this category in order to address the increased claims costs being experienced presently in minor severity injury claims. A process of internal review by insurers is an appropriate first step to determining any dispute that may arise but thereafter, the interests of fairness to a claimant demand that their rights are properly protected.

The common law diagram is designed to meet the following objectives:

1. Ensure early and appropriate oversight of common law claims to achieve timely and cost effective outcomes;

2. Restrict disputes before MAS to "gateway" determinations with limited rights of further assessment or review;

3. Promote quality assurance in the medical determination process by overview of permanently appointed CARS Assessors and judicial review only on the sanctioning of SIRA;

4. Compulsory settlement conference or mediation for early resolution once the common law "gateway" has been met;

5. Appropriate disincentives to proceed to a CARS assessment conference or Court hearing where resolution is not achieved at a compulsory conference.

The role of the Common Law Case Manager is key. Their role will not be dissimilar to that of a Judicial Registrar or List Judge in the District or Supreme Court in that they will be accountable to SIRA for ensuring all common law claims continue to be managed towards resolution. Where liability is admitted in full and the gateway met, the Common Law Case Manager would make appropriate directions for an insurer to continue to pay treatment,

rehabilitation and weekly loss benefits to a claimant in order to ensure optimal health outcomes including rehabilitation to work are achieved.

Transparency in the decision making process through the reporting of CARS decisions will further promote quality assurance with the intention of there being very limited, if any, need for the CARS Assessors' reasons to be subject to Review or scrutiny by a Court.

A claimant who elects to pursue an entitlement to modified common law benefits should be appropriately compensated for the cost of managing their claim through the dispute resolution model. The recovery of legal costs in our model will be geared to the efficacy of the claim following the compulsory conference. There needs to be an appropriate disincentive for either party to proceed to a CARS assessment conference or Court hearing where resolution is not achieved at a compulsory conference. This costs disincentive should be in keeping with the relative financial clout of the parties so that vulnerable claimants are not exposed to the same level of costs risks as an insurer.

3. Questions posed by the Reference Panel

3.1 What would the narrative test proposed by the legal profession look like? Specifically how would you define the level or type of injury or impairment and what mechanisms should be included so it is not easily eroded?

The Reference Panel is referred to Section 1.2 above.

3.2 If the legal profession's suggested approach to medium severity injuries is not cost effective, considering the objectives for reform, does the profession have an alternative option?

The Reference Panel is referred to Section 1.2 above. A range of adjustments could be made to the nature and extent of benefits available in order to reduce premium but preserve fairness for those who are in most need following a motor vehicle accident.

The legal profession has at all times been prepared to address the cost effectiveness of any alternative schemes. However, we are unable to do so unless we have available the relevant actuarial data. Despite requesting this material it has not been provided. Further, Ernst & Young has not costed the profession's March 2016 proposal with respect to legal costs, despite our request that it do so. In this respect we attach a letter forwarded to the Minister addressing these issues.

3.3 What model would you recommend in preference to a joint medical assessment for the initial medical assessment?

The legal profession submits that an initial joint medical assessment requires the informed consent of the claimant and insurer. In the claimant's case this requires either a lawyer's advice or at the very least, the involvement of claimant lawyer representatives in the selection of the assessment panel of medical experts. This is necessary to safeguard neutrality and independence.

In a large number of cases there will be no need for a medical report during the period of defined benefits.

Where there is a dispute, it should be referred to a MAS Assessor or to a CARS Assessor with the claimant having the right to obtain legal assistance.

For those who seek common law entitlements, it is a matter for each party to obtain their own medical reports, noting that the proposed revised Claims Handling Guidelines should be gazetted with appropriate incentives to utilise jointly appointed medical experts and mandatory disclosure of each party's independent medical assessment within 28 days of receipt of the report.

3.4 What reforms, if any, might improve the medical assessment process when a dispute has been lodged with the Medical Assessment Service ("MAS")?

The Law Society considered the issue of reforms to the Medical Assessment Service in its submission of 6 May 2016 in some detail. The Reference Panel is referred to section 6.1 which provides the reasons for and examples of significant delays in the MAS process. The submission recommended the following reforms:

- Removing causation as a medical assessment matter under section 58 of the *Motor Accidents Compensation Act 1999* to be determined by MAS.

- Allowing Claims Assessors to determine what injuries are caused by an accident – drawing on the impairment assessed for each alleged injury by the MAS assessor, a Claims Assessor determines the entitlement to damages for non-economic loss.

- Restricting each party to one Application for Further Assessment before lodgement of a CARS Application for General Assessment. Any subsequent Application on one or more further occasions may only be made by a Claims Assessor or by a Court but only if he/she is satisfied that all additional information about the injury that he/she considers relevant has been provided.

We consider that these recommendations meet the objectives of the reform process by reducing the time it takes to resolve a claim and thereby reducing premium costs. Claims costs in multiple MAS disputes are significant. It would also ensure more severely injured claimants are properly compensated through a consistency in the assessment of damages.

The Reference Panel will appreciate from the legal profession model for dispute resolution at 2.2 above that we have built the above proposals for MAS into the model. An efficient and cost effective medical assessment process should be managed by a CARS Assessor in order to ensure the advancement of claims to resolution in a timely manner. In addition, the only scope for seeking judicial review of a MAS decision is with the sanctioning of SIRA. This facilitates an internal review mechanism of medical assessors' reasons and provides a safeguard to claimants against overzealous insurers seeking to use the administrative division of the Supreme Court as an appeal process.

3.5 What are your views on how profit normalisation (clawback) should work? Additionally what are your views on the recommendations in the Report of the Independent Review of Insurer Profit?

The legal profession strongly supports the implementation of a profit normalisation (clawback) system. On the introduction of the *Motor Accidents Compensation Act 1999* there were three to four years of super profits in the 25% to 35% range. It is entirely unacceptable that any such super profits (at least twice the expected return) be permitted on implementation of a major restructure of the current legislative provisions.

Unfortunately, moving to a broader no fault (defined) benefits base involves a significant element of unpredictability. The number of claims, the severity of injury and the extent to which claims behaviour will be modified is going to be inherently unpredictable. That will

have insurers seeking larger prudential margins. That in turn gives rise to the prospect of super profits. A clawback provision is thus essential.

The legal profession does not have the technical expertise to design the structure of such provisions. To the extent that the CTP insurers have spent fifteen years filing premiums averaging 8% return, while actually recovering in excess of an average of 19% return, gives rise to the strong suspicion that there is some gaming of the system in terms of premium filings and profit yields. It is far better that those with expertise in actuarial modelling, premium underwriting and filing and insurer behaviours who are independent of the CTP insurers contribute to the drafting of a clawback provision that will not be readily manipulated by the CTP insurers.

The legal profession is able to make the following observations:

(a) The clawback has to cut in at a practical and realistic level of yielded profit. This probably is not 8%, but the legal profession defers to experts as to what is a realistic yield from a mandatory product. At anything more than 10% to 12%, the question starts to arise as to whether too high a premium is being paid for the security of private underwriting in a scheme that has so far proven effectively to be risk-free in relation to the making of very substantial profits.

(b) It is unrealistic that any clawback could be returned to the motorists who have paid the premium – the bureaucracy involved in sending back cheques would appear prohibitively expensive. It seems likely that the far more sensible mechanism is to have the clawback utilised to meet SIRA and Nominal Defendant expenses, thus reducing ongoing premium costs.

(c) Given that it will be two to three years into the first year of operation of a new scheme before first year profits start to become clear and any clawback can be applied, any clawback provision is going to have to be operative for a good number of years into the new scheme. If the clawback were to apply to the first five years of operation of the new scheme, then the money being clawed back would still be being drawn in ten years into the operation of the new scheme. Cutting off any clawback after a year or two simply encourages manipulation by insurers to hold up or disguise the realisation of profits.

(d) The Minister has commented as to the desire to incentivise insurers. A full clawback risks stripping all incentive out of the scheme. A graduated percentage clawback above certain levels may retain incentives, while still restricting excessive super profits.

Separately, the legal profession supports the vast majority of the recommendations contained in the Report of the Independent Review of Insurer Profit. If amendments to prudential requirements and increases in regulatory powers are required, then the legal profession supports them.

The introduction of a risk pooling mechanism in relation to higher risk insureds is supported as a mechanism of promoting price competition elsewhere within the market.

The only concern the legal profession has in relation to the recommendations is the social utility of broadening the *malus* range. Almost inevitably this will result in price reductions for those who can best afford the premium and price increases for those who can least afford the premium. Hardest hit will be the younger and vehicle dependent, low paid workers from Western Sydney.

The restriction in the malus range within the Sydney metro area is socially progressive – it redistributes wealth and risk between higher and lower income earners. The legal profession does not support broader risk rating if it unduly affects the less well off.

Further, there is support for the continuing cross-subsidy of younger drivers. All motorists benefit from that subsidy over time, in as much as everyone has a turn to be a younger driver (receiving the subsidy) and then a turn at being an older driver and providing the cross-subsidy.

3.6 What are your views on increased powers for the regulator to set and deal with service provider behaviour?

The legal profession supports the regulator having whatever powers are necessary to regulate insurer conduct.

When it comes to other service providers such as the legal profession and the medical profession, it is noted that both those service providers already have regulatory bodies to which they are highly accountable. The legal profession does not support having SIRA set up as a general regulator of either the legal profession, or the medical profession, in competition with existing bodies.

There are already means by which SIRA can regulate the interaction of lawyers and doctors with the CTP scheme through costs regulations, claims guidelines and the like. If there is to be greater regulation of conduct beyond that provided by the existing regulatory bodies, then the basis for such need should be clearly identified.

If there is to be a code of conduct with disciplinary penalties for failure to comply, those disciplinary penalties should be administered by existing professional bodies rather than being vested in a separate regulatory body such as SIRA.

3.7 What would you recommend be included in the content of any Codes of Conduct developed for the new scheme – these could cover insurers, lawyers and health service providers?

The legal profession would be happy to be part of a consultation process designed to develop Codes of Conduct. The Victorian Transport Accident Commission Protocols 2016 ("TAC Protocols 2016") may provide some useful guidance. Those Protocols were established by agreement between the TAC, Law Institute of Victoria and the ALA to provide an efficient, expeditious and transparent process to benefit delivery and dispute resolution.

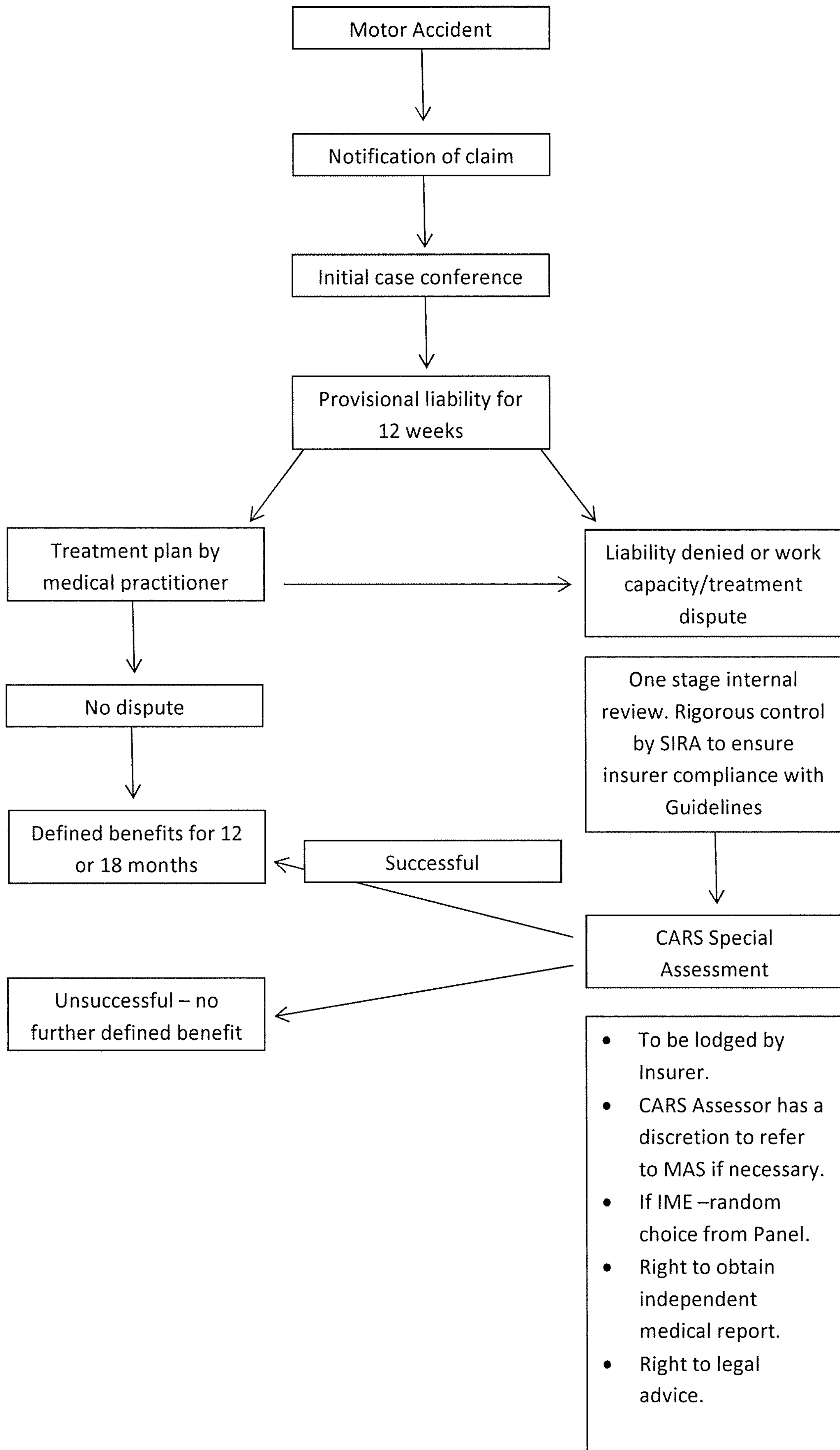
Thank you for the opportunity to provide further feedback. If additional clarification or explanation is required by the Reference Panel, our representatives would be happy to attend a further meeting.

Should you require any additional information, please contact Leonora Wilson, Policy Lawyer at the Law Society of NSW on 9926 0323 or email leonora.wilson@lawsociety.com.au.

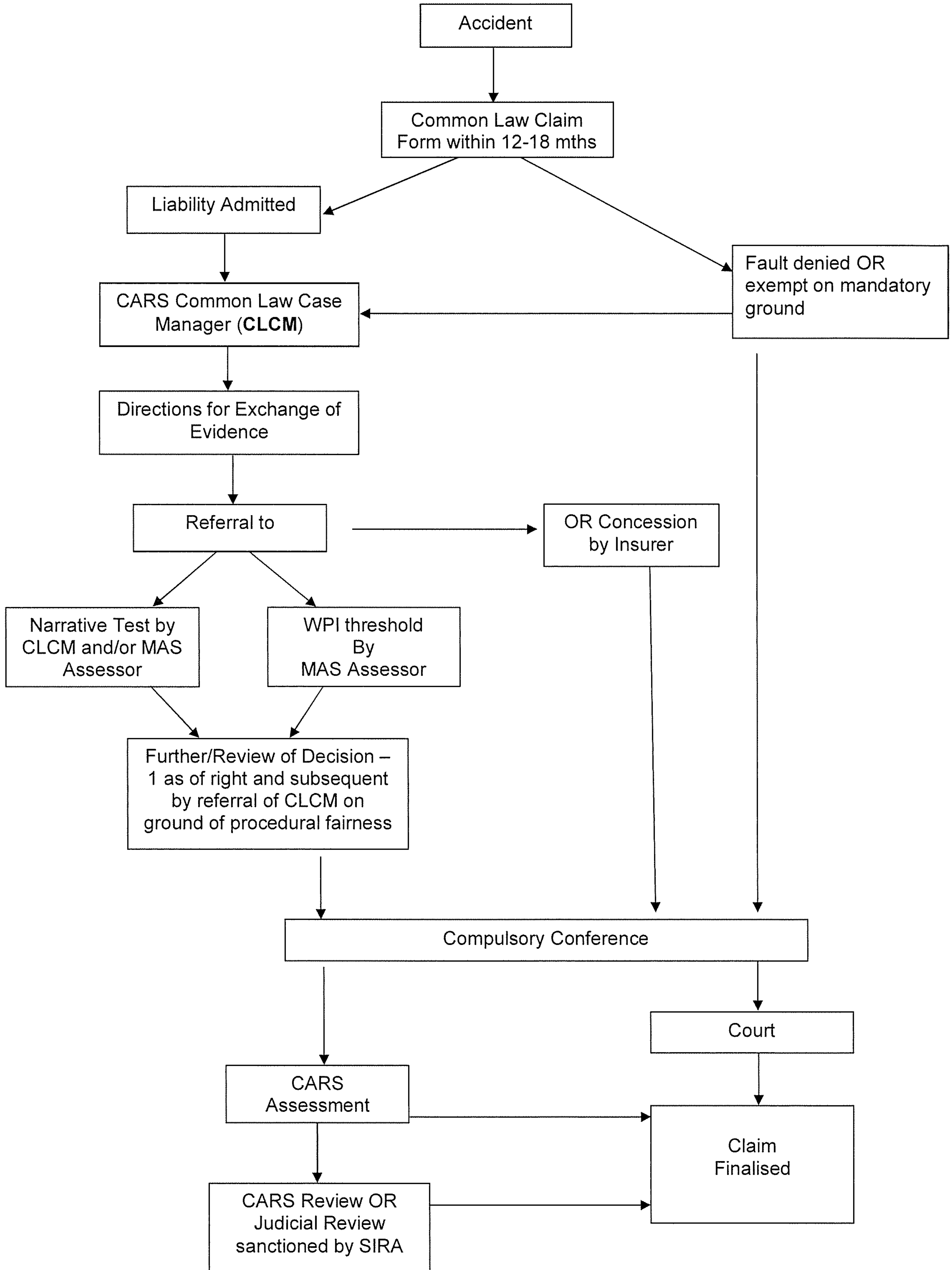
Yours sincerely,

Gary Ulman **President** **Law Society of NSW**	Noel Hutley SC **President** **NSW Bar Association**	Roshana May **NSW Branch President** **Australian Lawyers Alliance**

DEFINED BENEFITS FLOWCHART



DISPUTE RESOLUTION – COMMON LAW



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