



NEW SOUTH WALES  
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Our ref: InjuryComp:GUml1187340

29 July 2016

The Hon John Della Bosca and  
Ms Nancy Milne  
CTP Reform Reference Panel  
C/O Mr 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](mailto: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. We comprise the Law Society of NSW, the NSW Bar Association and the NSW Branch of the Australian Lawyers Alliance (“ALA”).

We have appreciated the opportunity to be involved in a number of consultations with the CTP Reform Reference Panel (“Reference Panel”).

We seek this opportunity to underline the issues addressed in our discussions with SIRA representatives and you over the past few weeks.

The legal profession has already made detailed submissions to the Government in relation to the re-design of the NSW CTP scheme, copies of which are attached for the benefit of the Reference Panel. The NSW Bar Association has also provided detailed case studies to the Reference Panel to illustrate just how unfairly the imposition of a 10% WPI threshold can operate.

We remain opposed in principle to the abandonment of the current NSW CTP scheme and its replacement with an inadequate and unfair workers compensation-style model. We reject the 'straw man' proposal put forward by SIRA as it is unfair to those with moderate and severe injury and who are not at fault, and therefore does not meet the reform objectives of fairness and reduction in premiums.

## 1. Problems with the 'straw man' proposal

The 'straw man' proposal fails to meet a number of the Government's stated objectives for CTP reform. In particular, the 'straw man' proposal fails to:

- increase the proportion of benefits provided to the most seriously injured road users (and particularly innocent victims);
- reduce the time it takes to resolve a claim; and
- reduce opportunity for fraud.

We have addressed you on the problems with the SIRA 'straw man' proposal, as follows:

### (a) Long-tail scheme design

It is a long tail scheme design with five separate long-tail components:

- treatment and care expenses for those over 10% and at fault;
- treatment and care expenses for those over 10% and not at fault;
- weekly economic loss payments for those at fault over 20% WPI;
- five years of weekly payments for children to be paid between ages 18 and 23; and
- every claim being open for at least five years.

The insurers have indicated that they do not support a long-tail approach because it lacks actuarial predictability. Claimants do not want a long tail because they do not want to spend a lifetime dealing with an insurance company. Lump sums give people self-control, self-determination and the capacity to move on with their lives. This desire is consistent with the general principles of the International Convention on the Rights of Persons with Disabilities (Article 3), which promote respect for individual autonomy and inherent dignity of individuals.

A point made repeatedly during the consultation is worth emphasising again – that the NSW CTP scheme has been predictable and stable in relation to the evaluation and determination of medium and high severity injury claims. The blow-out in the scheme has been entirely in relation to small claims.

The more radical the proposed changes, the greater the actuarial uncertainty going forward and the greater the need for excessive prudential margins to be built into premiums. The more closely the "solution" can be aligned to current scheme experience, the more actuarially predictable it will be and the lesser the need for excessive prudential margins, profit clawback mechanisms and the like.

The 'straw man' proposal mandates insurers to 'keep their books open' for up to 80 years or more in the case of a young child. For example, where trauma is suffered in an accident by a pregnant mother resulting in a child being born with cerebral palsy or other neurological disorder, the child's claim will remain open for their life expectancy with no entitlement to participate in the Lifetime Care and Support Scheme and significant future medical and related treatment needs. It will be appreciated that such an outcome would give rise to a need for ongoing monitoring and supervision of medical and related treatment needs and in turn, create friction between the insurer and claimant as to what is reasonable and necessary.

Even a five-year drip feed of benefits for the less severely injured requires insurers to keep open their claims book on the basis that a claimant can access benefits at any time during that five years regardless of whether it runs chronologically or aggregates. While ever a claim remains open, it is included in premium calculation even if no benefits have been paid on the claim in the preceding year or will be paid on the claim in subsequent years. For example, an office worker who fractures their non-dominant arm has a need for treatment in the acute post-injury period but may thereafter have no ongoing need for treatment or suffer no economic loss.

We do not find acceptable that a CTP insurer can sell their 'book' to a third party agency such as iCare which will assume management of the claimant's benefits. We understand that this suggestion is unacceptable to insurers as they will lose connection with their 'customer/consumer/client'.

(b) Fairness

The economic reality is that the CTP scheme cannot afford extensive no fault benefits for drivers who cause accidents and to extend proper "fairness" to those with medium severity injuries and permanent losses under 10% WPI.

We support the protection of innocent accident victims ahead of at fault drivers when it comes to long-term benefits. We have no issue with the extension of the ANF scheme to provide 12 to 18 months of no fault benefits for everyone, on the basis that the vast majority will recover from their injuries within that time frame. However, extending no fault benefits out to a five-year period for all, regardless of fault, on a lifetime basis for treatment for those over 10% WPI and on a lifetime earnings basis for those over 20% WPI, removes any capacity to provide "fairness" to innocent accident victims.

(c) Design "cliff" at 10% WPI

There is a design "cliff" at 10% WPI that will encourage disputation. Claimants and insurers will fight to preserve rights and contain claims costs respectively. If the 10% WPI threshold is determinative of future entitlements, there is significant risk to each party and a potential to drive claimants to surgery earlier than otherwise indicated, leaving them more susceptible to a poor long-term health outcome.

For example, a claimant who suffers a lower back injury in an accident resulting in a pre-existing asymptomatic canal stenosis becoming symptomatic with non-verifiable radiculopathy but acute pain (5% WPI) is invariably treated conservatively until the claimant can no longer tolerate the pain being experienced. That period is subjective but invariably more than five years post-accident. Subsequent spinal fusion surgery gives rise to a 20% WPI and an entitlement to modified common law damages.

(d) AMA IV and WPI assessment

AMA IV and the WPI assessment is a crude tool for measuring entitlements and does not measure treatment needs or earnings loss. It is a medical model (rather than a psycho social model) which fails to take into the unique circumstances of the individual. An alternative model which does attempt to measure a person's functioning and disability in a context is the International Classification of Functioning, Disability and Health ("ICF"), which was endorsed by the World Health Organisation in May 2001.

Impairment as a measure of the injured person's entitlement to benefits has the potential for unfair and inequitable outcomes. For example, a claimant at fault who has a successful two level cervical fusion for their neck injury would be assessed to have a 25% WPI and ongoing rights to treatment, but the not at fault claimant who has a compression fracture in the lumbar spine with 25 to 50% compression would be assessed to have a 10% WPI and no ongoing benefits past five years post-accident.

(e) Legal representation

We have real difficulties with the very significant restraints placed upon legal representation within the proposed defined benefits system, especially where a significant future entitlement to weekly benefits and/or medical expenses is at stake. A "right" to a benefit is of no use to you if you are forced to fight without a lawyer against a well-funded and experienced insurer who is determined to say no to maximise its return to shareholders.

(f) Illegality

With an estimated 7000 at fault claimants to come into the scheme, insurers are likely to be vigilant in seeking to exclude no fault entitlements on the basis of "illegality". Where criminal charges are challenged, a claimant will not receive benefits until there has been a successful defence and this may be some years after when the acute need for treatment arose. There is also scope for illegal conduct not leading to a successful prosecution resulting in significant benefits to the at fault person (as per the example in point (c) above).

(g) Workers compensation model

The 'straw man' proposes a version of merit review developed by the workers compensation regulator in the NSW Workers Compensation Scheme, which has not been successful and reduces both cost and disputation by removing access to justice for the majority of injured claimants. The proposed merit review system would fail on most, if not all, of the performance measures detailed on page 6 of the International Framework for Tribunal Excellence published by the Council of Australasian Tribunals ("COAT") in November 2012.

The current dispute resolution procedures are effective. While some modifications of procedure (as outlined in the Law Society submission) and greater independence in decision making is supported by the legal profession, the inequity and lack of fairness that exists in workers compensation (where there has been significant complaint and an acknowledged need for further reform) should not be duplicated in the CTP insurance scheme out of a misplaced desire to streamline dispute resolution under the two statutory schemes.

## **2. Alternative scheme proposal**

### Three-part scheme structure

We suggest a three-part scheme structure involving:

- 12 to 18 months of no fault ("defined") benefits for everyone;
- Significantly restricted common law benefits extending thereafter for those who can both prove fault and are under the threshold for common law damages; and

- The current broader range of common law benefits for those who can establish fault and are over an approved threshold.

These three elements are briefly addressed as follows.

(a) Statutory no fault benefits

We support the provision of no fault ("defined") benefits for 12 to 18 months.

A significant majority of claimants would be expected to return to work or have recovered from their modest injuries within a 12 to 18 month statutory benefits period. Twelve to 18 months of no fault payments is not a lifetime, but rather is a "leg-up" to get all injured people back on their feet post-accident. However, the provision of benefits beyond 12 to 18 months (short of catastrophic injuries in the LTCS scheme) should have its primary focus on innocent accident victims rather than those who cause accidents.

We submit that this approach meets the Government's objectives in terms of extending fairness to all accident victims, encouraging return to work, early payment of lost wages and treatment expenses, whilst preserving fault based benefits for the more seriously injured (which is not exclusively limited to those over 10%).

We are content for this system to operate on a third party basis with an insurer clearing house to allocate claims. There should be simple and straightforward dispute resolution mechanisms for all claims, which will assist in significantly reducing dispute resolution timeframes.

There is no issue with the first port of call being the insurer internally reviewing its own decision, provided there is far more rigorous enforcement than has occurred to date in terms to ensure that this process involves genuine review. However, there should be substantial penalties for insurers who invariably uphold their own decisions internally, only to have a significant percentage of them overturned externally on further review. If such patterns emerge, then the insurer internal review mechanism is exposed as being irrelevant.

If an insurer is going to dispute the statutory benefits on the basis of eligibility (or the weekly benefits at issue are much in excess of 12 months or children are involved), then that decision involves a more significant dispute and more substantial legal representation for the claimant will be required, especially having regard to the legal resources the insurer is able to allocate to the dispute.

(b) Medium severity injury, loss past 12 to 18 months, can prove fault

In part, the claims blow-out in unmeritorious or low severity injury claims has been due to insurers allowing cushions for care and future economic loss that were otherwise unwarranted. That practice is already changing as a consequence of better insurer investigation, enforcement and claims handling.

The legal profession has already put forward suggestions as to restrictions in costs in relation to children's cases and further restrictions on contracting out for costs. These restrictions constitute significant barriers to the pursuit of unmeritorious or low severity injury claims.

We propose to preserve less generous modified common law (with **no** non-economic loss damages) to protect those innocent victims with moderately severe injuries who have a serious and long-term loss of earning capacity and/or require ongoing treatment and medical needs. We envisage this group to comprise roughly 20 to 30% of those innocent claimants.

Our preferred position for access to ongoing benefits regarding medium severity injuries would be a narrative test based on need. This need should take into account the claimant's own circumstances and environmental factors, as is achieved under the ICF model. Those who can establish an ongoing loss of earnings and/or an ongoing need for treatment and can establish fault ought to recover a lump sum to cover their future losses. That would be the "fairest" result for this group.

The appropriate response to a claims blow-out in this area does not necessarily have to involve one single barrier, but can comprise a number of disincentives to pursue unmeritorious claims.

If it was felt that a broad narrative test did not provide sufficient disincentive to access ongoing benefits, then the alternative would be a "hard number" test, such as 6% WPI. This approach however involves multiple drawbacks, such as:

- more disputation over the WPI assessment; and
- unfairness, e.g. the labourer who cannot work with a 4% ankle fusion or shoulder injury, the 0% WPI assessment for the loss of seven teeth and \$200,000 in lifetime dental expenses, etc.

With reservations as to the complexity of the following suggestion, a 6% WPI threshold for access to benefits past twelve months could be modified as to its potential unfairness by a secondary test – only recovery of lump sums for future treatment and/or future loss of earnings where the amount awarded exceeds a threshold - \$25,000 or even \$50,000 in each category.

This would ensure that those with serious injury below 6% WPI would still receive adequate compensation. Actuarial concerns about any number being a "target" for lawyers needs to acknowledge that, where very significant sums are set as the threshold, then only those with serious injury will clear the hurdle.

Determination of such cases should remain within the CARS system. Claimants should be entitled to recover regulated costs only within that system. The deterrent previously proposed by the legal profession in terms of a restriction on contracting out below a certain amount (whether that be \$50,000 or \$100,000) will serve as a very significant secondary disincentive to pursue unmeritorious claims.

With considerable reluctance, we acknowledge that awards for voluntary domestic assistance may need to be removed from this category. Claimants who have a genuine need for such assistance should be encouraged to seek early commercial assistance as a reasonable and necessary treatment need.

Where the insurer wants to dispute liability, then those cases should be determined by the court system. CARS is not equipped for liability determinations and the disputes they involve.

Similarly, children's cases should continue to be dealt with by the court system, with its protective jurisdiction. To stop any blow-out in the costs of children's cases, the

very restrictive costs regime for children's cases previously put forward by the legal profession (copy attached) should be adopted.

Finally, within this category (and for the scheme overall), the system for the assessment of injury and eligibility for damages using whole person impairment gives rise to far too many disputes. An Injury Severity Rating ("ISR") system such as has been adopted in South Australia or Queensland is worthy of consideration (provided that the maximum amount for pain and suffering is an appropriate NSW scale, rather than the far more savage and unrealistic awards for pain and suffering that applies in those two States).

The scale itself works. The numbers other States attach to it are inappropriate. As an alternative to the ISR system, the ICF model is comprehensive and has been adopted by the NDIS and is worthy of close consideration.

(c) Common law damages

We propose to maintain existing modified common law benefits for those who are able to claim damages (with the exclusion of gratuitous care). Of most importance, our alternative scheme does not adopt the 'straw man' proposal to marry a fixed (unfair and totally inadequate) payment of non-economic loss damages to impairment value. This proposal flies in the face of media statements by the Minister which manifest a desire to protect the rights of the seriously injured. We reiterate that only 12 to 13% of innocent victims are able to pursue such a claim (roughly 1,700 claimants per year) and this 'cohort' has been stable for over a decade, with very little demonstrable disputation over the majority of heads of damage but most particularly non-economic loss.

For those who do not reach the common law threshold (whatever that may be) and establish fault:

- i. CARS assessments should not be made binding on the claimant. Very few cases proceed from CARS to a re-hearing. As discussed, insurers can average out the good, the poor and the unjust results over their claims portfolio. A claimant only has one claim and is entitled to a greater degree of individual justice and a right of re-hearing, albeit rarely exercised and with punitive costs restrictions;
- ii. The current range of common law benefits should be retained. The suggestion that there should be prescribed amounts for non-economic loss (with unrealistically low figures attached) as contained in the "straw man" proposal should be discarded forthwith. It seems entirely inconsistent with the Minister's public statements to strip \$200,000 or more in payments for pain and suffering away from the seriously injured;
- iii. The mandatory exemption of matters where liability is in dispute should remain. These cases are more appropriately dealt with in the court system; and
- iv. Contracting out of costs restraints should continue to be allowed on larger claims. The reality is that insurers will throw very substantial resources at large claims. The claimant should be entitled to a legal team which is able to provide all legal services necessary where required. If the insurer knows that the claimant is going to run out of costs at a certain point (due to capping of contracting out) then the insurer can effectively exhaust the claimant's legal resources at an early stage in the claim, leaving the claimant vulnerable. The insurers' knowledge that the

claimant's lawyers are able to provide full representation at all stages modifies and controls insurers' behaviour.

#### Additional key features

In addition to the three-part scheme structure outlined above, we emphasise the following key features of our alternative hybrid model:

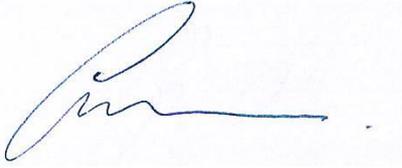
- (a) At fault drivers should not be compensated by payment of benefits for life, no matter the severity of their injury (except for those with catastrophic injuries who fall into the Lifetime Care and Support Scheme; we do not advocate for any change to Lifetime Care). The existing social welfare safety measures provided by Medicare and Centrelink have been and should remain a sufficient and appropriate mainstay for such claimants.
- (b) Beyond the statutory 'defined benefits' period, legal costs should be capped in smaller fault-based claims. In our joint letter to Minister Dominello dated 23 March 2016 ([attached](#)) we outlined how this could work to immediately remove incentives for 'exaggerated claims' and claims harvesters. Our proposal is designed to eliminate or significantly reduce legal costs for small claims (up to a value) and thereby discourage lawyers from enabling small claims to be made where there was otherwise no intention on the part of the injured person to otherwise do so.
- (c) Consistent with the understanding that there is a cohort of claimants who have moderate severity injuries resulting in ongoing incapacity and a need for treatment, these claimants' rights need to be protected by proportionate and appropriate legal representation. As no proposal has yet been forthcoming regarding regulated legal costs, the legal profession look forward to the opportunity to consult and negotiate on this issue.
- (d) Maintain the ability to settle claims. There are significant health benefits for claimants being able to put the accident behind them and move on with their lives. Further, premium cost will be better contained if the number of active claims at any one time is reduced.
- (e) Maintain the CARS dispute resolution system and ensure the changes proposed in the "Claims Assessment & Resolution Service Strategic review: Update February 2014" are implemented.

The legal profession's proposals retain the elements of the present scheme which have been stable for some time. We believe our proposed changes to the scheme drive fairness for the injured and result in greater actuarially predictability, objectives that are difficult to reconcile with the 'straw man' proposal. It is less likely to cause premium padding for uncertainties because many of the elements are known and data is available. Claimants will receive a greater proportion of the claim dollar. Payments will go to claimants faster.

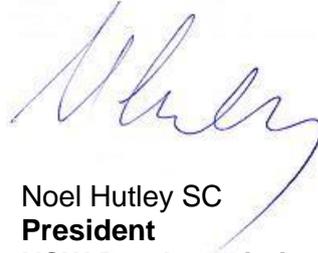
If further clarification or explanation would assist the Reference Panel, our representatives would be delighted to meet with you further.

Should you have any questions or require further information, please contact Meagan Lee, Policy Lawyer at the Law Society of NSW on 9926 0214 or email [meagan.lee@lawsociety.com.au](mailto:meagan.lee@lawsociety.com.au).

Yours sincerely,



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