THE LAW SOCIETY
OF NEW SOUTH WALES

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Our ref:JDhm703423

5 April 2013

The Hon Greg Pearce MLC
Minister for Finance and Services
Level 36 Governor Macquarie Tower
1 Farrer Place
Sydney NSW 2000

Dear Minister

Reforms to the NSW Compulsory Third Party Green Slip Insurance Scheme

Thank you for the opportunity to provide submissions in response to the Government's recent proposed reforms to the Compulsory Third Party Green Slip Insurance Scheme.

In light of the Law Society's conviction that it is unnecessary to embark on a complete overhaul of the existing CTP scheme, we have been pleased to work with the NSW Bar Association and the Australian Lawyers Alliance to develop an alternate proposal for reform. Should it prove necessary to pursue changes to the system following detailed and transparent consultation, the Law Society believes that the alternate proposal outlines an achievable model for securing greater efficiencies in the scheme and reducing premiums.

The Law Society's Injury Compensation Committee has also undertaken a detailed review of the February 2013 discussion paper and has provided a number of comments to the Motor Accidents Authority (attached for information).

I look forward to discussing these matters with you.

Yours sincerely

John Dobson
President

THE LAW SOCIETY OF NEW SOUTH WALES
170 Phillip Street, Sydney NSW 2000, DX 362 Sydney T +61 2 9926 0333 F +61 2 9231 5809
ACN 000 000 699 ABN 98 696 304 966 www.lawsociety.com.au

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JOINT SUBMISSION

The New South Wales Bar Association
The Law Society of New South Wales
and
The Australian Lawyers Alliance

AN ALTERNATIVE PROPOSAL TO REFORM THE NSW CTP SCHEME

New South Wales Bar Association

THE LAW SOCIETY OF NEW SOUTH WALES

Lawyers for the People
AUSTRALIAN LAWYERS ALLIANCE

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1. EXECUTIVE SUMMARY

The legal profession recognises and supports the government's objectives in seeking to reform the CTP scheme:

(i) Reducing premium costs.

(ii) Faster resolution of claims, especially small claims.

(iii) Reducing levels of disputation.

(iv) Directing benefits to the more seriously injured.

(v) Maintaining private underwriting.

However we believe that these objectives can be achieved more quickly and with greater certainty by modifying the existing scheme than by embarking on a wholesale re-design of CTP insurance in NSW. This proposal by the NSW legal profession focuses on the development of an alternative reform model focussed on streamlining scheme benefits and reducing disputation.

The impact of these reforms has been costed by Deloitte Actuaries & Consultants Limited ("Deloitte") and is expected to deliver a premium that comes back below $500.

At the outset, it is important to acknowledge that the CTP scheme is more complex than workers' compensation – more complex injuries, fewer small claims, more complex financial circumstances for claimants (not just the employed but the self-employed, unemployed, students and children). Given the complexity of these reforms, they should not be rushed. Nor should they be implemented until the proposal is properly costed. The broad costings done by Ernst & Young have not been released or reviewed.

The legal profession believes that moving to a comprehensive no fault scheme will give rise to a range of risks and disadvantages for motorists and therefore the NSW community at large. Specifically:

1. The proposed premium savings may not be delivered due to the 7,000 extra claims for at fault drivers; higher claims handling costs (more claims); and insurers requiring higher prudential margins due to uncertainty about the new scheme's operation.

2. The proposition that accident victims should surrender benefits to provide payments to the drivers who caused their injuries raises genuine issues of fairness.

3. It is doubtful that motorists will be financially better off when all circumstances are taken into account. If victims cannot recover the full measure of their lost earnings, many people will need private income protection insurance to protect their family home and quality of life in the event of a car accident. This additional cost will more than offset any CTP premium savings.

4. The Victorian Transport Accident Commission scheme is not a good model for NSW to follow as it is in deficit and government underwritten. A Victorian TAC-style scheme will not work in NSW with private underwriting and the intrinsic need for insurers to make profits. Victorian CTP premiums would possibly be higher than NSW if they had private underwriting.

5. There is no working model of a privately underwritten no-fault CTP scheme anywhere in the world. The Government's draft model is not a copy of Victoria (a government

underwritten scheme). It is therefore untested and risky, and alternatives should be considered.

6. Removing lawyers from the CTP scheme will see insurers (and their in-house lawyers) ride roughshod over the rights of accident victims.

7. The unreleased Ernst and Young costing for the proposed changes needs careful review, given that cost efficiency/savings is at the heart of the intended reform objectives.

The legal profession's proposal – as costed by Deloitte (copy attached) – could, by October 2013, deliver premiums under $500 and faster resolution of claims. By contrast a new comprehensive no fault scheme is likely to take between 12-18 months to be implemented and may ultimately not deliver premium savings and other desired benefits.

The key features of the legal profession's alternative proposal include:

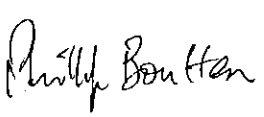
- Capping past and future wage loss payments on the basis that those on high incomes can have private income protection insurance. Compensate the full wage loss of lower income earners.

- Substantially restrict payments for voluntary and paid care.

- A variety of measures to reduce disputation within the scheme including:

  - Better exchange of liability information
  - Removing arbitrary late claim disputes
  - Prescription of answers for common contributory negligence disputes
  - Streamlining the Medical Assessment Service (MAS) and Claims Assessment and Resolution Service (CARS)
  - Improving the hardship payment system so that more benefits are paid out more quickly.
  - Better regulation of the legal profession for the protection of the public
  - Better regulation of insurers to ensure both sides in a dispute engage in the early resolution of claims.
  - Better regulation of premiums so that insurers cannot remove 30% of premium collected as profits.
  - Restricting the recovery of costs in small cases and providing for quick resolution of disputes with paper assessments.

All these measures could be delivered within the existing fault-based system. If the NSW Government believes that no-fault benefits should be expanded then we recommend this be done through the existing ANF scheme (where the effects on premium are predictable and containable) rather than by the broad adoption of a full no-fault scheme.



Phillip Boulten SC	John Dobson	Jnana Gumbert
President	President	NSW Branch President
NSW Bar Association	Law Society of NSW	ALA

2. INTRODUCTION AND OBJECTIVE

The discussion paper *Reforms to the NSW Compulsory Third Party Green Slip Insurance Scheme* presents a radical overhaul of the NSW Green Slip Scheme. At the core of the proposal is an expansion of benefits to cover not only those injured by negligent driving, but also the negligent driver. This will bring upwards of 7,000 extra claims per year into the system.

This expansion of coverage would be funded by substantial cuts to the current level of benefits paid to the innocent victims of motor accidents.

The discussion paper proposes termination of all benefits (including treatment expenses and wage loss) after an as-yet-undefined period (possibly 3 to 5 years) for 90 per cent of accident victims. Only about 600 people per year who get over the 10 per cent whole person impairment (WPI) threshold would have their future treatment expenses and wage losses paid.

The legal profession recognises that there is significant scope for reducing premium prices and improving the efficiency of the current CTP scheme. The Government's reform objectives are supported to the extent of:

(i) Reducing and stabilising premium cost.

(ii) Faster resolution of claims, especially small claims.

(iii) Reducing levels of disputation.

(iv) Directing benefits to the more seriously injured.

(v) Maintaining private underwriting.

It is submitted that these goals can be achieved within the framework of the existing scheme rather than the more radical, untested and unfair scheme re-design which the discussion paper puts forward.

This submission sets out an alternative proposal for the improved efficiency of the current scheme. This proposal has been costed by Deloitte Actuaries & Consultants Limited ("Deloitte") and is expected to deliver a premium that comes back below $500.

This submission also sets out concerns regarding the discussion paper proposal, including the substantial benefits cuts, the inevitable increase in insurer claims handling costs, potential reduction in competition (as insurers vacate the market) and possible increases in premium as insurers seek larger prudential margins to underwrite an untested no-fault scheme.

Significantly, there is no model for a privately underwritten, no fault scheme anywhere in the world. The government-run no fault accident compensation scheme in New Zealand has delivered massive deficits (currently $2.6 billion for the motor accident component of their scheme), whilst paying lower benefits than enjoyed by NSW accident victims. Last year, Victoria's government underwritten no fault CTP scheme (TAC) was $1.4 billion in deficit.

The discussion paper states that Victorian premiums are on average $362 before GST and input tax credit (ITC) loadings. This figure is questioned. A CTP newsletter published by Finity in August 2012 reported that average Victorian premiums at that time were $522.50 inclusive of GST. Victorian premiums are over $500 in a not for profit, government underwritten scheme. If acquisition and expense cost incurred by private underwriters in NSW were to apply in the Victorian scheme, and the premium was increased in response to

the recent deficit in that scheme, it is possible that the premium in Victoria would exceed $600. This would be more expensive than NSW.

The Government has had costings for the scheme proposed in the discussion paper prepared by Ernst & Young, however these figures have not been released or scrutinised.

The current NSW CTP scheme operates at no cost to government. With our proposed reforms, the scheme would operate more efficiently, more effectively and deliver affordable benefits to the most seriously injured.

3. CURRENT SCHEME COST AND PRINCIPLES OF REFORM

To understand the current scheme it is necessary to understand where the current premium goes. Insurer filings are not publicly released, but on the available data the average premium looks something like the following:[1]

MCIS (LTCS and MAA operating expenses)		$122
Benefits		$237
NEL	$36	
Economic loss	$95	
Treatment	$49	
Care	$45	
Other	$12	
Acquisition and claims handling costs (15%)		$65
Legal and Investigative		$49
Profit to insurer		$45
GST		$41
TOTAL		**$559**

The legal profession contends that there are four key areas that could be addressed to improve scheme performance:

1. Better targeted damages;
2. Improved scheme efficiency;
3. Regulating insurer conduct; and
4. Containing legal costs.

[1] Deloitte's report attached.

4. ALTERNATIVE REFORM MODEL – DETAILED PROPOSALS

The NSW legal profession has developed the following suite of alternative reform proposals for consideration and believes these will achieve the core objectives of reducing premiums to under $500 and improving the efficiency of the scheme (while preserving its fairness). The costing of these proposals has been undertaken by Deloitte Actuaries & Consultants Limited ("Deloitte")...

1. Better targeted damages

The following initiatives are proposed that will remove significant cost from the system while preserving some key principles of fairness:

a. Preserve current benefits for pain and suffering (for those who get over 10% WPI), past treatment expenses and future treatment expenses.

b. Preserve payments for future treatment expenses and future loss of earnings for all innocent victims of motor vehicle accidents. Do not cut off wage loss payments after an arbitrary 3 or 5 years.

c. Cap past and future economic loss at $2,000 net per week on the basis that those on higher incomes can and should take out personal income protection insurance.

d. Cap future loss of earnings to the retirement age (currently age 67).

e. Restrict access to past and future voluntary care payments to those who exceed the 10% WPI threshold. (We note that payments for voluntary care have been the primary driver in claims costs growth over the past decade and have also seen a substantial growth in the value of small claims and the delay in the resolution of those claims). This proposal not only significantly reduces access to this head of damage, but will also significantly improve the speed of resolution of small claims.

f. Restrict access to payments for past and future paid care to those who are over 10% WPI.

2. Improve scheme efficiency

We believe there are a range of reform measures that will reduce disputation and facilitate more timely outcomes for claimants:

a. Cut late claim disputes

Over 80% of claims are lodged within six months. Access to payments for treatment and lost wages is incentive enough to get claim forms lodged promptly. Insurers currently lose 90% of late claim disputes which are a disproportionately expensive drag on claims resolution. Remove the right for insurers to reject claims lodged within 3 years.

b. Make Section 81 work

Section 81 of the *Motor Accidents Compensation Act 1999* requires insurers to give a determination on liability within three months. This part of the current system is not operating properly, with technical disputes over distinctions

between *"liability", "fault"* and "*breach of duty of care"*. If this Section was clarified needless disputes would be avoided.

c. Share liability information

Insurers are currently required to hand over a copy of the police report, but no other material in relation to liability or contributory negligence. If the insurer wants to dispute liability or allege contributory negligence then they should hand over all relevant materials including their driver's statement, witness statements and accident investigations. If this information is provided to the claimant then disputes will be reduced. This requirement is part of the reason the Queensland scheme currently works more efficiently than the New South Wales scheme.

The same obligation to disclose liability information should be placed on claimants.

d. Prescribe some common contributory negligence deductions

Currently there is unnecessary disputation due to insurers making allegations of contributory negligence. Allegations of 100% contributory negligence are commonly made, but never proven. The discussion paper proposes trying to prescribe some fixed levels of contributory negligence. Subject to maintaining a requirement that the contributory negligence causally relate to the circumstances of accident and injuries, this proposal is supported.

For example, UK courts have traditionally held that where a failure to wear a seatbelt is involved, there is no contributory negligence if the failure did not contribute to injuries, 15% reduction if the failure partially contributed to injuries and 30% reduction if injuries were entirely caused by the failure to wear a seatbelt. Disputation in this area can be significantly reduced if fixed percentages along these lines are introduced.

e. Make the current hardship payments system work

Currently the *Motor Accidents Compensation Act 1999* provides for insurers to make advance payments pending final resolution of a claim. On some occasions, insurers do so willingly. In other cases, there are extensive and expensive disputes over modest advance payments. Provided the amount being sought by way of hardship payment does not exceed the total value of the claim, insurers should not object to making an interim payment. The only reason for an insurer to oppose an interim payment would be to keep an accident victim in difficult financial circumstances, in the hope that they would then settle their claim more cheaply.

The current hardship payment system does not work because the process is bureaucratic and insurers are allowed to generate needless disputes over what should be straightforward interim payments.

Efficiency can be improved by:

- Reversing the onus so as the insurer has to show why an interim payment should not be made; and
- Legislating for a presumption in favour of quarterly interim payments for those with loss of earnings as a consequence of an accident. (Quarterly payments avoid the tax complications that the weekly payment regime proposed by the discussion paper would involve).

f. Repeal Section 89A-E

Insurers and claimants want to settle cases without overly elaborate preparation for what should be a straightforward process. These legislative provisions require extensive preparations, add to costs, and create delay.

g. Improve the efficiency of the Medical Assessment Service

The Medical Assessment Service (MAS) and the 10% WPI threshold are at the heart of most claims delays. Unnecessary MAS assessments and repeated MAS assessments are the bane of the current system and must be a key target of reform. The efficiency of MAS can be streamlined by:

(i) Requiring claimants to apply to MAS for assessment of WPI within two years of the accident.

(ii) Prevent claimants from applying to MAS unless they have substantive evidence that injuries will be over the 10% WPI threshold.

(iii) Not permitting insurers to dispute the 10% WPI threshold where they hold evidence that injuries are over that threshold.

(iv) Allowing insurers and claimants to agree the nature and extent of injuries that are not in dispute and their percentage WPI, so that only injuries where there is a dispute are assessed at MAS (currently MAS assesses all injuries, even those about which the parties agree).

(v) Restrict reviews and further assessments to only looking at injuries in dispute, not re-assessing all injuries.

(vi) Limit further assessments at MAS by only permitting each side to apply for one such assessment (whilst maintaining the current requirement that there can only be a further assessment if the Proper Officer says there has been a material change in circumstances). There would still be the safety valve of a court or CARS having the capacity to refer again if an appropriate circumstance arose in a particular case.

h. Expand the role, and improve the efficiency, of CARS

(i) Reduce exemptions from CARS. The CARS system is a form of alternative dispute resolution that is cheaper and more efficient than court proceedings. Currently cases where greater than 25% contributory negligence is alleged are exempted from the CARS process. This should be changed so that CARS has the capacity to assess all cases involving contributory negligence allegations (subject to the safety valve of a discretionary exemption for clearly unsuitable cases). An exception should remain for infants and persons requiring tutors, where the courts should retain a supervisory jurisdiction.

(ii) Increase use of paper assessments and telephone conferences for small claims. Restrict costs in small claims to encourage rapid resolution.

(iii) Impose a limitation period for CARS. Currently delays are caused by the fact that there is no time restriction on applying to CARS for assessment of

the claim. We propose the same three year limitation period that applies in relation to court proceedings.

(iv) Restrict CARS re-hearings. The re-design of the current system in 1999 had two dominant features:

- Excluding pain and suffering payments for 90% of accident victims (the 10% WPI threshold); and
- Compelling insurers to accept the result of a CARS assessors' award.

The latter part of the system is not functioning properly. The current disincentives to claimants pursuing re-hearings are working. The legislation should be amended to prevent all insurer re-hearings of CARS assessors' awards. Currently insurers are not bound by CARS assessments of late claims and other special assessments.

i. Streamline workers compensation paybacks

Currently there is the anomalous situation where an injured accident victim's substantive rights will be determined in a CARS assessment whilst there is a simultaneous litigated court dispute between a workers compensation insurer seeking recovery of payments and a CTP insurer defending that action. These claims under s 151Z of the *Workers Compensation Act* involve unnecessary disputation and should be resolved by a bulk billing agreement between the workers compensation and CTP insurers. Such an agreement has been talked about for a decade. Implementation is overdue and will result in a significant scheme benefit.

j. Review the Lifetime Care and Support (LTCS) scheme and the Medical Care and Injury Services (MCIS) Levy

Over 20% of the CTP premium currently goes to support the LTCS scheme, which cares for the most catastrophically injured. Every motorist pays over $100 per year in premium to fund care and treatment for less than 200 people per year. Whilst recognising the need to provide proper care for the most catastrophically injured, there are serious concerns about the efficiency of the LTCS scheme. It appears to be collecting far more in premium than the level of benefits being paid out would justify, so a comprehensive review of the scheme is warranted.

3. Regulating Insurer conduct

There is significant scope for scheme savings on the Insurer side:

a. Reduce acquisition costs

Currently about 15% of the premium goes to cover insurer claims handling and acquisition costs. This is the case even though there is minimal price-based advertising in CTP, and insurers only use generic advertising that barely mentions CTP. It is generally conceded that this advertising is really targeted at the comprehensive insurance market. We contend that the green slip is a compulsory insurance for vehicle owners who should not be subsidising the costs of generic advertising and corporate sponsorship. The only allowance that should be permitted in the premium cost for insurer advertising is where such advertising makes specific reference to CTP price.

b. Set resolution targets and publish results

The MAA sets no targets for the resolution of claims and publishes no data on the relative performance of insurers in speed of resolution. Setting targets and publishing the results (identifying individual insurers) would create a positive incentive for insurers to push the rapid resolution of claims.

c. Pointless disputes ascribed to profit rather than operating costs

The discussion paper proposes that costs associated with unnecessary disputes should come from the profit component of the premium rather than operating costs. This is supported.

d. Add-ons to premium to be separately priced

Some insurers currently offer "*driver at fault*" insurance as part of the CTP premium. This makes comparison of price problematic. If an insurer wants to offer additional benefits then they should be separately costed as an add-on to premium, rather than inflating the base premium price.

e. Tighter regulation of premiums

For the past decade, premiums have been set on the basis that insurers should ultimately keep 8% of the premium written as profit. They have in fact averaged 19%. There is currently no capacity to claw back the 'super profits'. The Government should introduce and enforce a super profit levy such as 50% on all the realised profits over 12% of premium written.

The nature of the scheme means that these super profits would not be known and recoverable until some years post-premium collection, but if the levies were paid to the MAA, then over time, such payments could be used to reduce the MCIS Levy and cover the MAA's operating expenses. If there were consistent super profits then the income stream would ultimately be paid back to motorists through a reduction in the MCIS Levy and reduced premiums.

4. Legal fees and lawyers

The vast majority of lawyers acting for the injured do so honestly, ethically, and reasonably. Few accident victims could afford legal representation if they had to pay for it upfront. The current system only works because lawyers are prepared to take cases on a speculative basis.

There has been legitimate public criticism of the charging practices of one, now defunct, law firm. That firm's practices were not typical of the profession. Overcharging is abhorred by honest practitioners and condemned by the Law Society, the Bar and the ALA.

The MAA's own study (an FMRC Report) showed that lawyers in the CTP scheme charge conservatively and reasonably. Nonetheless, recognising that there have been rogues, and the need for protection of the public, the following suggestions are made:

a. Abolish referral fees

Doctors and agents should not be recovering spotter's fees for referrals.

b. MAA oversight of costs

Give the MAA power to review solicitor/client bills and, in suspected cases of overcharging, make referrals to the Legal Services Commissioner.

c. Introduce the claimant as primary beneficiary rule

In the vast majority of cases, the claimant receives the bulk of the settlement. However, to prevent any abuse, introduce a rule in similar terms to section 347 of the Queensland *Legal Profession Act*.

d. Costs in small claims

To further improve efficiency and speed of resolution, remove party/party legal costs for settlements or awards under $20,000 and restrict the recovery of solicitor/client legal fees to a maximum of $2,000 for any settlement or award under $20,000. Combine this with increased use of simplified paper assessments for small claims.

5. EXPANDING NO FAULT BENEFITS

One further proposal that could be considered in revising scheme design would be to expand the current Accident Notification Form system and expand no fault benefits.

The legal profession has significant concerns about expanding the no fault element of the scheme:

(i) The propensity to claim increases.

(ii) Claims handling expenses increases as claims numbers increase.

(iii) The incidence of fraud increases.

(iv) Pure no fault schemes reduce incentives to make roads, motor vehicles and drivers safer.

(v) The risk grows of insurers leaving the scheme and decreasing competition, leading to increased premiums.

However, if there is to be an expansion in no fault benefits then it is suggested that this be done in a much more restricted fashion than the comprehensive model set out in the discussion paper. For example, the current no fault ANF could be expanded from $5,000 up to $20,000 on the basis that this would reduce disputation and speed up the resolution of small claims. No costs are payable by the insurer on ANF only claims, so expanding the ANF does significantly increase the claims resolution rate and drive down costs in small claims.

Deloitte estimate that expanding the ANF to $20,000 on a no fault basis would produce a net saving to the scheme of $4 per premium. (The extra benefits paid are more than offset by reduction in overall claims costs, reduced payments for legal fees, and quicker resolution of small claims.)

6. CRITIQUE OF PROPOSALS IN THE DISCUSSION PAPER

As a preliminary contextual point, it is important to acknowledge that while it is true that NSW does have higher premiums than some other Australian jurisdictions, there are a number of reasons for this. Firstly and most importantly, better benefits are paid in NSW. NSW provides lifetime care on a no-fault basis (unlike Queensland) which adds over $50 to NSW premiums. (South Australia has just introduced a Lifetime Care Scheme which is projected to add $60 to premiums). NSW has various other no-fault benefits.

Second, the risk in the NSW scheme is privately underwritten. This add costs. The Victorian government scheme is currently running at a $1.4 billion deficit. If acquisition costs incurred by private underwriters in NSW were to apply in the Victorian scheme and the premium was increased in response to the recent deficit in that scheme it is possible the premium in the Victorian Scheme would exceed $600.

Unlike the MAA, Queensland's *Motor Accident Insurance Commission* has controlled premiums and restricted insurer profits. If the MAA did the same, NSW would have cheaper premiums too. (Queensland also does not have an LTCS scheme paying for catastrophic injury on a no-fault basis. If the LTCS levy was added to the Queensland premium then their prices would be much closer to NSW.)

The NSW legal profession believes that there are serious risks and weaknesses associated with the reforms proposed in the discussion paper.

1. The proposed premium savings are uncertain

Implementing a completely new scheme involves considerable price risks including:

- The strong likelihood that insurers will be allowed a high prudential margin in premiums in initial years. This will force prices up rather than down.
- The possibility that some insurers will drop out of the market, reducing price competitiveness and placing upward pressure on premiums.
- Increased insurer administration costs (to handle 7,000 more claims per year and deal with time-consuming weekly payments), reduces any saving that could otherwise be achieved.
- Propensity to claim will increase from under 50% to over 100%.

The proposals outlined in our submissions would result in a conservative estimate of approximately $60 in savings to current premiums. These savings could be delivered immediately.

Conversely, given the large increase in staff numbers and new computer systems required by the proposal embodied in the discussion paper, we understand that CTP insurers will not be able to operate a new system for another 12-18 months. Clearly any premium cuts would not be achieved until the system was up and running. There are legitimate concerns this scheme would increase rather than cut premiums.

Because our proposals involve modifying an existing scheme, rather than creating a completely new one, it is easier to identify the savings that could be achieved, and there is more likelihood that premium price would remain stable into the future.

The two inflationary drivers (small claims and care payments) have been directly and permanently addressed by the legal profession's alternative proposal.

The discussion paper proposals are not fully costed. Given that significant details are missing (such as when benefits are cut off for most claimants), the claimed savings from scheme reform are speculative and uncertain.

2. Victims punished in order to pay the driver at fault

Innocent motor accident victims are substantially disadvantaged under the proposed changes:

(i) No loss of wages after 3-5 years for those who are not over 10% WPI (which is 90% of accident victims). The government has not announced its intention in relation to the cut-off point for benefits.

(ii) Injured children may not be compensated for their future inability to work or restriction in work capacity (if not over 10%).

(iii) Reduced wage payments for everyone.

Although the reform proposals may deliver earlier payments (TAC style), the injured would still be at risk of losing their homes if those payments are insufficient to cover the mortgage and living expenses (which in many cases they will be). They would certainly lose their home after 3-5 years when they are on the unemployment scrapheap.

3. Motorists will lose financially

The costs savings being offered on the model in the discussion paper are in the order of $50-$75, however the financial modelling for this scheme has not been released. Assuming these savings did materialise, they would be more than offset by the need for all drivers and passengers who work to have income protection insurance because the Motor Accidents scheme no longer protects them by covering their permanent wage loss. The cost of the required income protection insurance substantially outweighs the saving. For the many who cannot afford income protection insurance, the changes will simply mean they will be under-insured in the event of a motor vehicle accident, putting them at severe financial risk should they be unable to continue working.

4. Insurers will win, claimants will lose

The anticipated reduction in legal representation means that accident victims will have no-one to assist them in dealing with insurance companies. The Claims Advisory Service is not a substitute for proper legal advice and advocacy. The available evidence shows that those who were unrepresented get vastly lesser settlements for comparable injuries than those who are represented.

5. The Victorian Scheme is a poor model for NSW

The TAC scheme is not an attractive model to copy. It is a government underwritten scheme. It is currently in deficit to the extent of $1.4 billion.

A privately underwritten scheme cannot run at a deficit. With private underwriting there must be a profit to insurers. If acquisition costs incurred by private underwriters in NSW were to apply in the Victorian scheme and the premium was increased in response to the recent deficit in that scheme it is possible the premium in the Victorian Scheme would exceed $600.

6. Lawyers add value

Legal fees within the scheme are not excessive. On the data in the MAA's own discussion paper, total legal and investigative fees are 12 percent of premium collected, with claimant legal fees at around 6 per cent. Total payments for legal fees have not increased over the last 4 years.

The legal profession value adds to scheme performance and assists all other scheme stakeholders:

(a) The legal profession helps the claimant by ensuring people are informed of their rights and providing a check and balance against the otherwise unrestrained power of the insurers. With independent advice, claimants are reassured they obtain a "fair" result.

(b) The legal profession helps the insurers by helping educate claimants about their rights and avoiding unnecessary disputes. The insurers and CARS Assessors report that it is far more difficult to deal with unrepresented claimants than it is to deal with professional and experienced advocates.

(c) The legal profession helps the MAA as an industry regulator. By and large regulatory control of the insurers is out-sourced to the legal profession – they are the ones who identify, protest about and prevent heavy-handed insurer conduct. Without the legal profession performing this role, the MAA would be required to be a far larger and far better industry regulator than it is currently set up to be. The only other alternative is to give the insurers untrammelled power within the system.

THE LAW SOCIETY
OF NEW SOUTH WALES

COPY

Our ref:JDhm703410

5 April 2013

Mr Andrew Nicholls
General Manager
Motor Accidents Authority of NSW
Level 25, 580 George Street
SYDNEY NSW 2000

Dear Mr Nicholls

Reforms to the NSW Compulsory Third Party Green Slip Insurance Scheme

Thank you for the opportunity to comment on the NSW Government's proposed reforms to the Compulsory Third Party Green Slip Insurance Scheme set out in the February 2013 discussion paper (the discussion paper).

The Law Society has reviewed the proposals and contends that there is minimal evidence to suggest that the current CTP scheme requires extensive change. There is certainly scope to increase efficiency, but this can be achieved within the existing scheme rather than creating what is effectively a new system with all the associated risks. The Law Society is particularly concerned about the lack of detail provided in the discussion paper, such as would enable even a well-informed observer to determine whether the proposed reforms are likely to lead to a reduction in premiums or otherwise. Although the discussion paper refers to "independent cost estimates of the proposed Scheme design" (page 5), these have been withheld to date. It is of significant concern that this and a number of other documents which are clearly relevant and in existence have not been publicly released, including the following:

1. The 2012 NSW CTP Scheme Performance Update by Ernst & Young
2. The peer actuarial report which would have been done following the Ernst & Young report
3. The final report issued by Co-Solve following the Claims Assessment and Resolution Service review process in 2010 during which process numerous Law Society members were heavily involved
4. The report of LEK Consulting who were engaged as part of the scheme review and who were paid $503,670 in the 2012 financial year for "CTP pricing strategy development" (refer to page 62 of the 2012 Motor Accidents Authority annual report)
5. The final recommendations of the 2010 Costs Regulation Working Party

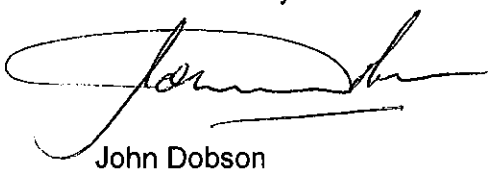
The Law Society is concerned that there has not been full disclosure of this material in circumstances where what is under consideration is fundamentally a novel scheme. We characterise it as novel because we are aware of no other model for a privately underwritten no fault motor accident scheme anywhere in the world. The motor accident component of the no fault accident compensation scheme operated by the Accident Compensation Corporation in New Zealand is $2.6 billion in deficit in net terms according to the latest Financial Condition Report issued by ACC as at 30 June 2012. The Victorian TAC scheme which is also underwritten by the State Government was in deficit by over $1 billion for the last financial year as set out in its 2012 annual report. The Law Society fears that the proposed new scheme will achieve similar financial results if it has not been appropriately costed. This is likely to have particularly serious consequences in NSW because ours is a privately underwritten scheme where the insurers may decide to desert the system if losses of this magnitude are being suffered. The Law Society therefore submits that any reform process should only be embarked upon after thorough analysis and following a detailed consultation with the legal profession and other stakeholders. This is only possible once the concrete details of the proposed changes have been made available, including costings.

The Law Society's Injury Compensation Committee has undertaken a detailed review of the discussion paper and provides a number of comments in response, which are attached.

The Law Society continues to advocate for a fair and sustainable system of CTP Green Slip Insurance in NSW. We use this opportunity to renew our request for the release of the documents referred to above so that stakeholders can express an informed view about the future of the scheme.

Please contact my office (9926 0216) or the Chief Executive Officer (9926 0215) if you would like to discuss any of the matters raised in this submission.

Yours sincerely



John Dobson
President

Injury Compensation Committee comments on the discussion paper

The Law Society's Injury Compensation Committee provides the comments below in response to the specific sections of the discussion paper:

1. How the Green Slip Scheme works

The Committee is concerned that the table headed "Fast facts – NSW Compulsory Third Party Green Slip Scheme" presents a misleading picture of the operation of the scheme. For accident years earlier than 2007 (for example 1999/2000 and 2000/2001), the number of claims were significantly in excess of the claims that are ultimately predicted to be made for the 2012 year. It is also important to note that the number of claims includes accident notification forms as well as fully fledged claims. In this context the accident notification form provisions were expanded in April 2010 to include at fault drivers who were then able to pursue provisional payments up to $5,000. Accordingly it is inadequate to compare the total number of claims in 2007 to the number in 2012, which will include a significantly greater proportion of ANFs. The graph, for instance, which is shown in the December 2012 edition of the MAA Bulletin at figure 1 clearly demonstrates that the upsurge in overall claims over the last few years has been largely driven by the increases in ANFs rather than any upsurge in what are described as "full claims". This is only to be expected given that persons who had not previously had a remedy are now encouraged to make a claim with limited reporting requirements, noting that an ANF application is ordinarily only about two pages long.

The Committee has a similar concern about the figures that are quoted for "numbers of claims per 10,000 vehicles". Various annual reports of the Motor Accidents Authority confirm that the relevant figure for "claims frequency" for the 2004/2005 financial year was 29, then 30 for 2003/2004, 32 for 2002/2003 and it was 36 for the 2001/2002 accident year. The Committee suggests that, far from being an indication of a significant upsurge in overall claims frequency, this figure of 29 is no more than a return to a more realistic figure for claims frequency based on the overall claims experience over a number of years.

Similar comments can be made in relation to the increased figure for "propensity to claim" between 2007 and 2012. The 2012 MAA Annual Report at page 75 concedes that the increased level of propensity to claim "may have been impacted to some extent by the expansion of the ANF scheme to include at-fault drivers from April 2010". The Committee would go further and suggests that this propensity figure is largely due to the expansion of the ANF scheme, firstly to increase maximum payments from $500 to $5,000 and then to expand ANFs to include at-fault drivers. Again this can be demonstrated by figure 1 which is shown at page 2 of the December 2012 edition of the MAA Bulletin.

The decrease in affordability from 28% of average weekly earnings in 2007 to 37% in 2012 also does not tell the full story. This is because Lifetime Care only commenced for adults as from 1 October 2007 so this inevitably has entailed an increase in the average cost of premiums for all subsequent accident years.

The figure for scheme efficiency is dealt with elsewhere in these comments.

2. Why the NSW Green Slip Scheme needs to change

The central theme here seems to be the preference for a no fault system over a fault based system together with concerns regarding the negotiation and dispute process, delays and legal costs.

In relation to the question of a proposed no fault scheme, the Committee has the following difficulties:

(a) If it is proposed that an extra 7,000 claimants be able to access benefits even if they are at fault, then the system must be prepared to accept the extra infrastructure which will be involved. For instance there will need to be far more CARS and MAS assessors appointed and the insurers will need to engage further claims staff to cope with this extra influx of claims. It is not known whether costings for the new system have made allowance for this extra infrastructure cost.

(b) The Committee questions the policy underpinning the scenario where a negligent driver of a vehicle readily accesses compensation whereas the person who was injured is able to access far less compensation than he or she would currently receive, in order to subsidise the costs of the claim for the negligent party.

(c) There is minimal evidence that a no fault system achieves any better health outcomes than a fault based system. The Authority will have access to the studies of Ms Nieke Elbers who delivered a paper on this topic to the MAAS annual conference in November 2012.

In relation to the question of the delay in accessing benefits, the Committee would like to see the existing hardship payment system work better than it currently does. In particular, section 84A only makes provision for interim payments in cases of financial hardship. The Committee's experience is that claimants are faced with onerous requirements for the particulars which need to be provided in order to establish this financial hardship. There is no reason why claimants should have such stringent obligations placed upon them to provide detailed information in relation to financial hardship. Provided the claimant can comfortably satisfy the CARS assessor that there is sufficient money likely to be awarded following determination of the claim to allow for an interim payment then it should be available.

The Committee accepts that there are some difficulties with the negotiation and dispute resolution process. However these problems can be addressed without a complete overhaul of the system. A large part of the delay associated with the CARS process arises from unnecessary delays at the MAS with repeated further MAS applications and reviews. Further delays are experienced because of the relatively ease with which both claimants and insurers can avoid the CARS process especially in cases involving, for example, infants or where liability is denied or contributory negligence is alleged at more than 25%. These delays can be considerably shortened by expanding the powers of CARS assessors to deal with matters that are currently dealt with by the courts. The other difficulty with the current system is the unnecessary formality of the pre-filing requirements contained in sections 89A to 89E and in section 91. These provisions require a level of formality which mandates unnecessary legal work and cost at an earlier stage in the proceedings than would otherwise be required. These pre-filing requirements should be removed in preference to a less formal dispute resolution process which could, perhaps, be presided over by CARS assessors or by mediators without excessive documentary requirements which simply serve to increase costs. As far as MAS is concerned, the role of MAS assessors in determining causation of injuries could be removed. This is entirely consistent with the current practice in the Workers Compensation Commission jurisdiction. Over recent times the courts have demonstrated the difficulties MAS doctors have experienced in wrestling with concepts of legal causation which should now be determined by CARS assessors. If MAS assessors are to have any role at all, then it should solely be in the assessment of whether the claimant passes the required threshold to recover damages for non-economic loss. A further answer to the problem of MAS delays is to limit the number of further assessments whilst retaining the power of a CARS assessor or a judge to refer a matter himself or herself for further medical assessment under section 62(1)(b) of the Act.

In relation to the question of legal costs, the Committee wishes to place on record that it abhors the conduct of an extremely small minority of practitioners who have been

responsible for overcharging in this area. However, the vast majority of lawyers acting for the injured do act honestly and provide invaluable access to justice by funding the costs associated with preparing the case for hearing generally on a no win/no fee basis. There are rigorous mechanisms in place to constrain any overcharging of legal costs, including mandatory disclosure requirements at the time of taking instructions and the costs assessment process through the Supreme Court. The FMRC report to the Authority dated December 2008 in relation to solicitor/client legal costs also indicates that lawyers operating within the third party scheme generally charge reasonably. The concern raised in the report published following the Eleventh Review of the Standing Committee on Law and Justice was "that the legal costs regulation had not kept up to date with contemporary legal fees". No concerns were raised there as to the quantum of solicitor/client legal fees. The only criticism in the report was levelled at the inadequacy of the party/party legal costs which resulted in a significant gap between the fees charged to the client and the fees that were actually payable by the insurer pursuant to the Regulation. Nevertheless, and with a view to reinforcing the existing safeguards with respect to legal costs, the Committee proposes that the MAA should have power to review solicitor/client bills and, in suspected cases of overcharging, make referrals to the Legal Services Commissioner.

2.1 Green slip prices are too high

It is unfair to compare NSW with other States with dissimilar systems and with dissimilar rights. Most importantly the NSW system provides added benefits which are not available in other States such as the Lifetime Care and Support Scheme and the subsidisation of public hospital and ambulance fees (on a no fault basis) as well as the blameless accident provision and the at fault ANF payments along with the special benefits scheme available for children (again on a no fault basis). The Committee is concerned that any question of comparison between the States should be on an "apple for apple" basis and not by comparing apples to oranges. In any event, significant savings can be achieved within the existing scheme by relatively straightforward reforms such as those we have suggested above. Another suggestion to save money would be the abolition of the whole late claims regime which, in the Committee's view, is horribly inefficient. The vast majority of these late payment applications are successful (something in excess of 90%) yet they represent a disproportionate cost to the claims resolution process.

2.2 The Scheme is highly inefficient

In relation to the graph on page 6 of the discussion paper, the Committee makes the following points:

(a) The 50% figure for claims payments is at odds with the efficiency rating of 64% which is quoted at page 73 of the 2012 MAA Annual Report. This appears chiefly to be because the efficiency rating quoted in the Annual Report includes Lifetime Care participants, whereas the efficiency ratings quoted in the graph do not take into account Lifetime Care payments. It is difficult to understand why the different methodology has been adopted in the two efficiency ratings. In any event, the Committee notes that at page 73 of the Annual Report, it was stated that "despite the economic volatility over this period (from 2007 to 2012) this index (the scheme efficiency rating) has remained relatively stable".

(b) The discussion paper then goes on to say that the "main reason for the inefficiencies are insurers' expenses (such as acquisition costs), higher than predicted profit margins because of the uncertain nature of the scheme and legal and other overhead expenses involved in negotiating and disputing settlements". In a scheme where it was initially acknowledged that an 8%

profit margin was reasonable, the profit margins have been as high as 30% in two of the early years of the system (refer to page 74 of the MAA Annual Report). The Committee can well recognise that these windfalls to the insurer have made the system less efficient then it would otherwise have been. In order to reduce such inefficiencies into the future, it is proposed that the Authority should adopt some system whereby excessive profits are retained in a fund for use in the harsher economic times, such as the present.

(c) The Committee also finds it difficult to understand how legal expenses can be considered a significant part of the inefficiency of the system when only 12% of the total payments under the scheme relates to legal and investigation costs. Presumably, this means that the legal costs comprise both plaintiffs' and defendants' solicitors (although not any fees paid by the plaintiff in addition to the scheduled costs recovered from the insurer). This does not seem to be disproportionate to insurers' profits which comprise 19% of the total pie. Further, according to page 80 of the 2012 MAA Annual Report, it should also be noted that legal payments have, in fact, reduced between 2007 to 2012.

(d) It is only to be expected that smaller claims where the total value is less than $50,000 will be the least efficient if legal representation is involved. Regrettably this is because the same amount of work is required to prepare a smaller claim compared to many larger claims. The claimant's solicitor is still required to comply with all the onerous pre-filing requirements and to proceed through the MAS process even if the claim ultimately amounts to less than the sum of $50,000. However, the Committee takes the view that the value added by solicitors to the potential worth of the claim generally significantly outweighs whatever cost the law firm may charge.

2.3 Claims frequency and propensity are increasing

Again, the Committee is concerned about the potential for distortion in the figures for claims frequency and propensity as set out in the discussion paper. Most, if not all, of the recent increases in the figures for claims frequency and propensity can be attributed to the expansion of the ANF regime since 2008 to cover claims for expenses up to $5,000 and then to cover "at fault" drivers from April 2010. The Committee accepts that there has been an increase in the proportion of claims payments made for care over the years of the scheme and is happy to consult with the Authority on ways of addressing this growth in care claims.

2.4 Delayed payment of benefits

The Committee takes the view that any delay in benefits will be significantly reduced by improvements in the existing scheme as detailed above.

2.5 New South Wales compared with other States

The Committee notes that this section includes a case study which makes reference to the Victorian Transport Accident Scheme. What this case study does not demonstrate is that the system is in deficit by more than $1 billion. It also does not state that lost income payments are only made for up to 18 months at which time a vocational capacity assessment is performed. Payments can only be made thereafter for a maximum period of another 18 months if ongoing loss of earning capacity is demonstrated. This inevitably leads to many claimants being left without benefits after three years unless they can demonstrate a sufficiently serious injury to

enable access to the limited common law rates which are available under the TAC system.

For the reason stated above, the Committee does not accept the proposition that no fault systems are likely to produce generally superior health outcomes compared to fault base systems. This simply does not accord with the conclusions reached in research to date including those contained in the studies of Ms Nieke Elbers.

3. Moving to a better scheme

3.1 Principles for reform

The Committee largely agrees with the principles for reform as outlined at 3.1. However, most of these principles can be achieved by mending the existing system rather than creating a new one. For instance, the Committee accepts the general proposition that health outcomes are likely to be optimised where injured people are assisted as soon as possible. However, this can be achieved within the existing system by making it more difficult for insurers to dispute liability for medical expenses at an early stage in the proceedings. Perhaps a more expedited method of assessment of medical treatment disputes can be developed, at least in the early stages of a claim. For instance, the imposition of a reverse onus to require insurers to disprove that a claim is reasonable and necessary may be appropriate if the relevant medical expense relates to the first 12 months after the accident. Whilst it is theoretically desirable for there to be a consistency of administration and benefits and dispute resolution mechanisms across NSW compensation schemes, it must be recognised that the NSW workers compensation scheme is fundamentally different to the third party scheme. For a start, the third party scheme deals with numerous categories of injured persons including children and those who have retired and those who are not working, whereas the workers compensation scheme solely deals with workers. This has practical implications, particularly if, for instance, it is proposed that something similar to the work capacity assessment regime in the workers compensation realm be adopted. The emerging experience of many practitioners in dealing with the work capacity assessment regime is that it is skewed in favour of the insurer with no right of legal representation. This is because the insurer has access to experienced claims managers with a good deal of experience and training in the assessment of work capacity, whereas most workers have little or no knowledge of the law.

3.2 Universal cover

We have already articulated above why we believe that a no fault scheme is a risky proposition. If this proposition is to include standard deductions for contributory negligence, then the Committee takes the view that this is inappropriate. The assessment of contributory negligence should be made on a case by case basis given that there are many cases where, for instance, the failure to wear a seat belt or a helmet may not have contributed to the accident or the injuries at all. The Committee also notes that instances of fraud and frequency and propensity to claim will all increase exponentially under any no fault system. It is the Committee's understanding that propensity to claim under the TAC system is something in excess of 100% rather than 52% as is currently the case in NSW.

3.3 Third party cover

The Committee submits that it is naïve to believe that an insurer will be more motivated to look after the claimant if they are the insurer's own customer than would be the case in an adversarial system. This simply would not eventuate in practice.

The vast majority of claimants would not have enough business to offer the insurer to make an impact one way or the other in terms of improvement of the insurer's practices. A more effective option would be to establish wider availability of efficiency figures and dispute resolution statistics for individual insurers. The Committee can readily imagine that many well informed drivers would be more willing to insure with an insurer who has lower disputation rates or who, for instance, settles claims within a shorter time frame.

3.4 Payments made sooner based on need

The Committee believes that it is desirable to allow claimants to access some payments sooner rather than later but this can be achieved by streamlining the existing hardship payment system. The Committee does not support any system which is similar to the NSW workers compensation system or to the Victorian TAC system if this inevitably means that loss of income benefits are terminated after an artificial period of no more than five years. This does not recognise that many people (even those assessed under 10%) have real injuries which are likely to impact on their capacity to earn until retirement age and not just for another period of between 18 months to five years.

3.5 Simple claim system

The Committee is keen to explore any proposition that will involve the simplification of the claims system. In particular, the Committee supports the contention that the current claim form is unnecessarily long and deters injured persons from lodging a claim at all. The Committee supports provision for rehabilitation assistance but this does not mean that workers should be unrealistically pushed back into the workforce when they are simply not in a physical position to do so. It also should not mean that workers are automatically cut off from benefits if they do not successfully transition back to work. Many injured persons, even those below 10%, will realistically never be able to return to full time work and the system must be sufficiently flexible to recognise this.

3.6 Common law will be retained for some

The Committee supports the retention of common law rights for those above 10% whole person impairment. What the Committee does not support is the contention that any injured person who is assessed below 11% whole person impairment is not seriously injured. The Committee is well aware of numerous cases where injured persons have been assessed at below 11% whole person impairment yet they are never likely to work again. For instance, a person who works as a gyprocker or a builder's labourer may only achieve an impairment rating of 5% or 10% due to a disc injury yet he or she, in most cases, will effectively not be able to work into the future taking into account the highly physical nature of the work involved and noting that most workers of this type have limited alternative work experience.

3.7 A simpler scheme with disputes

Whilst the Committee supports the general contention that a simpler scheme is desirable, this does not mean that a one size fits all approach should be adopted in relation to those persons who are assessed at below the 11% impairment threshold. Any system must be sufficiently flexible to recognise that even injuries which do not achieve this threshold may still have a significant impact on an injured person's past and future earning capacity. For this type of worker a scheme which is simplified in the terms proposed will be a far less fair scheme. The Committee also does not accept the proposition that there is necessarily likely to be less need for legal

assistance in any statutory benefit scheme. The work capacity assessment regime which has been adopted in the worker compensation context is already demonstrating how imbalanced a scheme can become where one party has little or no knowledge and bargaining power and the other has access to more trained and more sophisticated staff. On the other hand, the Committee supports the suggestion that insurers should have their licence condition linked to their performance in managing claims effectively and it also supports the strengthening of the role of the Authority by giving it new powers to set guidelines and to monitor and take action against insurers who fail to comply. It is unclear what is being proposed when it is suggested that an independent review officer be established similar to what operates in the NSW workers compensation system. If this suggests that the independent review officer have a role to review insurer's processes, then this is something that is supported. If, on the other hand, it is suggested that the independent review officer be some form of arbiter to resolve work capacity disputes without any legal representation, then this proposal is strongly disputed for reasons detailed above.

3.8 Some reforms to premiums needed

The Committee accepts that a review of the premium system is mandated with any expansion in no fault benefits. However, it is submitted that any assessment of future premiums should not make allowance for such high prudential margins as have been granted to insurers in the past.

3.9 Lower green slip premiums and better outcomes

The Committee submits that similar premium reductions will be achieved by making amendments to the existing scheme rather than constructing a new no fault scheme with the attendant risks.