THE LAW SOCIETY
OF NEW SOUTH WALES

Our ref: ICC:JWab300721

30 July 2021

State Insurance Regulatory Authority
Level 13 West, 2-24 Rawson Place
Haymarket NSW 2000

By email: consultation@sira.nsw.gov.au
statutoryreview@sira.nsw.gov.au

Dear Sir / Madam,

Statutory Review of the Motor Accidents Injuries Act 2017

The Law Society of NSW appreciates the opportunity to provide a submission in response to the Statutory Review of the *Motor Accident Injuries Act 2017* (NSW) ('**the Act'**) Discussion Paper ('**Discussion Paper**'), prepared by Clayton Utz. The Law Society's Injury Compensation Committee has contributed to this submission.

In the time available, we have prepared the below comments, but we look forward to further opportunities to comment as the review progresses, including as part of the stakeholder consultation meetings scheduled next month, and take this opportunity to reiterate key concerns made in our previous submissions **attached**, including:

- Submissions to SIRA on the Review of Legal Support for Injured People in the NSW CTP Scheme (December 2020),[1]
- Submissions to the Standing Committee on Law and Justice on the 2020 Review of the CTP Insurance Scheme (November and December 2020),[2] and
- Submissions to SIRA on its Review of the Minor Injury Definition in the *Motor Accident Injuries Act 2017* (September 2019).[3]

Our key concerns are as follows:

[1] The Law Society of NSW's 2 December 2020 Submission to SIRA on the Review of Legal Support for Injured People in the NSW CTP Scheme ('**2 December 2020 SIRA Submission**'); The Law Society of NSW's 21 December 2020 Supplementary Submission to SIRA on the Review of Legal Support for Injured People in the NSW CTP Scheme ('**21 December 2020 SIRA Supplementary Submission**').
[2] The Law Society of NSW's 9 November 2020 Submission to Standing Committee on Law and Justice on the 2020 Review of the CTP Insurance Scheme ('**9 November 2020 SCLJ Submission**'); The Law Society of NSW's 10 December 2020 Supplementary Submission to Standing Committee on Law and Justice on the 2020 Review of the CTP Insurance Scheme ('**10 December 2020 SCLJ Supplementary Submission**').
[3] The Law Society of NSW's Submission to SIRA on its Review of the Minor Injury Definition in the *Motor Accident Injuries Act 2017* ('**6 September 2019 SIRA Submission**').

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

1. The 'minor injury' definition is restrictive, and, in our view, often results in claimants being cut-off from statutory benefits prematurely. The definition can lead to arbitrary, counterintuitive and unfair outcomes for claimants for various reasons:

    a. The "minor injury" test as defined by the Act includes injuries which can have long-term consequences for an injured claimant, both in terms of employment capacity and day to day activities.[4]

    b. The Act focuses on the categorisation of pathology related to the injury, rather than accounting for real-life consequences flowing from the injury;[5]

    c. Certain spinal injuries causing serious flow-on consequences and disabilities are defined as minor injuries, regardless of their Diagnosis Related Estimate ('**DRE**') clinical diagnoses and whole person impairment ('**WPI**') percentages;[6]

    d. Many psychological injuries are not diagnosable for the purposes of the minor injury definition until after the 26-week statutory benefit period has elapsed and the definition of a minor psychological injury includes a chronic adjustment disorder which has long-term consequences for the claimant;[7]

    e. Determinations of whether an injury is a minor injury, and whether an injury is causally related to the subject accident, are binding determinations, despite the possible delayed onset of symptoms.[8]

2. The insurer internal review process for motor accidents is inefficient and ineffective for its intended purpose, as insurers have strong financial interests in the outcomes of review. As of March 2021, only 12% of insurer internal reviews for minor injury decisions resulted in a decision in favour of the claimant.[9] In this regard we note:

    a. Our members have reported the common occurrence of insurers attempting to classify injuries as minor injuries, disregarding ambiguity, through selective interpretation of medical evidence.

    b. This problem is exacerbated by the mandatory nature of internal review in the motor accidents space which is contrary to the decision in the workers compensation space that removed the need for a mandatory review of work capacity decisions.

3. The 20-month threshold to make common law claims for damages and 24-month threshold for settlements[10] is overly burdensome, especially considering the filtration of

---

[4] *Motor Accident Injuries Act 2017* (NSW) s 1.6 (definition of 'minor injury'); See 9 November 2020 SCLJ Submission (n 2) 2-3; See 6 September 2019 SIRA Submission (n 3) 3.
[5] 9 November 2020 SCLJ Submission (n 2) 3-5; 6 September 2019 SIRA Submission (n 3) 3.
[6] 9 November 2020 SCLJ Submission (n 2) 4-5; 6 September 2019 SIRA Submission (n 3) 4.
[7] 9 November 2020 SCLJ Submission (n 2) 5; 6 September 2019 SIRA Submission (n 3) 4-5.
[8] 6 September 2019 SIRA Submission (n 3) 5.
[9] State Insurance Regulatory Authority, *CTP Insurer Claims Experience and Customer Feedback Comparison* (Report, 31 March 2021) <https://www.sira.nsw.gov.au/__data/assets/pdf_file/0010/985321/CTP-insurer-claims-and-experience-and-customer-feedback-comparison-report-March-2021.pdf>.
[10] *Motor Accident Injuries Act 2017 (*NSW) s 6.23

small claims under the statutory benefits 'minor injury' scheme, and in our view contradicts the Act's object of encouraging quick, cheap, and just dispute resolution.[11]

4. In our view, the legal costs structure presents a hurdle to claimants accessing appropriate and timely legal representation, which in turn impedes early dispute resolution and is conducive to subsequent litigation, which, again, is contrary to the Act's object of encouraging quick, cheap, and just dispute resolution.[12] This can be attributed to various reasons, including:

    a. The minimal fees available to legal practitioners under the scheme, which provides a disincentive to provide comprehensive and early advice aimed at dispute resolution;[13]

    b. The $6225.60 per claim cap[14] on costs for medical treatment disputes having the potential to drive adverse insurer behaviour by incentivising the raising of repeated medical disputes until legal access under the cap is exhausted;[15]

    c. The reduced fee for practitioners where they can demonstrate that review is not merited, in comparison to the fee for matters proceeding to review, despite the likelihood that the same amount of work will be done for both;[16]

    d. The lack of provision for recovery of costs for initial or ad-hoc advice, and for services in disputes that do not proceed past the point of internal review;[17]

    e. Practitioners being required to apply to the Dispute Resolution Service ('**DRS**') for a merit review of legal costs and the costs only being payable by the insurer upon an order by DRS, rather than being entitled to legal costs irrespective of the outcome of the dispute;[18]

    f. Legal representatives not being able to receive fees for assisting claimants with complex pre-accident weekly earnings ('**PAWE**') calculations;[19]

    g. The Act not reflecting the fact that solicitors acting for persons without legal capacity are required to undertake more work, as per *GIO v Moon*;[20]

    h. The modest allowances for regulated (party/party) legal costs under the Motor Accident Injuries Regulation 2017 ('**the Regulation'**) and the removal of the right to contract out of regulated legal costs in damages claims worth less than $75,000 (Clause 25 of the Regulations).

---

[11] Ibid s 1.3(g); 9 November 2020 SCLJ Submission (n 2) 7.
[12] 2 December 2020 SIRA Submission (n 1); 9 November 2020 SCLJ Submission (n 2).
[13] 2 December 2020 SIRA Submission (n 1) 2; 9 November 2020 SCLJ Submission (n 2) 8.
[14] *Motor Accident Regulation, Schedule 3.*
[15] 21 December 2020 SIRA Supplementary Submission (n 1) 2.
[16] 2 December 2020 SIRA Submission (n 1) 2; 9 November 2020 SCLJ Submission (n 2) 9.
[17] 21 December 2020 SIRA Supplementary Submission (n 1) 1-2; 2 December 2020 SIRA Submission (n 1) 3; 9 November 2020 SCLJ Submission (n 2) 9.
[18] 2 December 2020 SIRA Submission (n 1) 3; 9 November 2020 SCLJ Submission (n 2) 10.
[19] 21 December 2020 SIRA Supplementary Submission (n 1) 2; 2 December 2020 SIRA Submission (n 1) 3-4; 9 November 2020 SCLJ Submission (n 2) 10.
[20] [2020] NSWSC 714: Wright J allowed for legal costs which exceeded the maximum costs fixed by the Regulation, in accordance with the circumstances set out in subsection 8.10(4) of the Act; 2 December 2020 SIRA Submission (n 1) 4-5; 9 November 2020 SCLJ Submission (n 2) 13-14.

5. The prescribed six-month period for claiming statutory benefits, irrespective of fault, raises issues for not wholly-at-fault or not mostly-at-fault claimants. Some insurers apply unreasonably high levels of contributory negligence, leading to ongoing and extended disputes, during which time claimants are severely disadvantaged due to their early cut-off from medical treatment and wages at the six-month mark.[21]

The Law Society's comments in response to the specific consultation questions are attached, and adopt the headings, numbering and definitions as provided in the Discussion Paper.

Should you have any questions in relation to this submission, please contact Ann-Marie Boumerhe, Acting Policy Lawyer, on (02) 9926 0187 or email Ann-Marie.Boumerhe@lawsociety.com.au.

Yours faithfully,

Juliana Warner
President

CC: David Gerber, Partner, and Mark Weise, Senior Associate, CLAYTON UTZ

Encl.

[21] 10 December 2020 SCLJ Supplementary Submission (n 2) 1-2.

Objective (a)

To encourage early and appropriate treatment and care to achieve optimum recovery of persons from injuries sustained in motor accidents and to maximise their return to work or other activities.

General questions

1. Does this objective remain valid?

Yes, the Law Society submits that objective (a) remains valid.

2. Are the terms of the Act, Regulations and Guidelines appropriate for securing this objective? If not, then in what respects and to what extent are those terms not appropriate for securing this objective?

The Law Society is of the view that the terms of the Act, Regulations and Guidelines are not appropriately securing the intended objective and that many claimants are not receiving the treatment and care they ought to be entitled to. We are concerned that the Act, Regulation and Guideline framework does not provide the right incentives for all scheme participants to ensure injured people receive appropriate treatment.

The framework can result in people not receiving appropriate treatment, and disputation as to what should and should not be covered by the scheme. For example, a claimant may present a referral for diagnostic imaging, such as an MRI, on the advice of their specialist or general practitioner. Ideally, the focus should be on whether the treatment is reasonable and necessary and relates to the injuries sustained in the accident based on the individual circumstances before them.

Our members report, however, that Clause 5.4 of the Motor Accident Guidelines, which states that diagnostic imaging is not considered necessary to assess minor injury, has been used to deny a request. This can deny access to useful treatment, as well as remove the opportunity to obtain evidence that may show that a non 'minor injury' exists.

The immediate impact of this example is that, ultimately, only claimants with the financial means to obtain their own diagnostic scans will have the opportunity to achieve optimum recovery, and have their injuries appropriately diagnosed and treated.

A second example which demonstrates how the Act, Regulation and Guidelines are not securing their objective can be found in the early treatment approval process. Under previous versions of the Guidelines, an initial consultation with a general practitioner and two treatment sessions with an allied health provider were pre-approved before an insurer had to consider whether further treatment was reasonable and necessary. Version 7 of the Guidelines (Clauses 4.74 to 4.75) now requires all treatment to be approved, effectively hindering an injured person from obtaining treatment immediately following the accident.

3. What is the evidence that the Scheme is, or is not, achieving this objective?

As noted above in response to question 2, the Law Society is aware of anecdotal examples of practises which undermine the effectiveness of the Scheme in providing early and appropriate treatment and care to maximise return to work and other activities. In addition to these, there are examples of participants in the scheme, including medical practitioners, being unaware of the protocols that the Act, Regulation and Guidelines dictate. As a consequence, delay and additional cost can be incurred by having to seek multiple reports to ensure that

medical reports conform to the legal requirements of the Scheme, which dictate whether treatment is available for a particular type of injury or not.

4. What changes (if any) should be made for the Act, Regulations and Guidelines to secure, or better secure, this objective?

A number of specific examples may improve access to treatment under the Scheme:

(i) Diagnostic imaging – Remove Clause 5.4 of the Motor Accident Guidelines, to eliminate tension that currently exists with Section 3.24 of the Act. If this resulted in additional costs, these could be offset by limiting the cost of diagnostic imaging, similar to what is commonplace in the Workers Compensation scheme. We note that Section 3.31 of the Act permits SIRA to limit the amount payable for any particular treatment or care in the Scheme.

(ii) Causation of Injury – Require insurers to proactively seek clarification on injuries from general practitioners, allied health providers and specialists upon receipt of medical evidence which is unclear or incomplete. This ensures that only accurate and informed decisions on causation and denial of treatment are made.

(iii) Initial Treatment – While not requiring a direct amendment of the legislative framework, a wide-ranging and continuous education campaign for general practitioners and allied health providers could improve the access their patients have to treatment before a claim is made, with approval from the insurer. The process for seeking such approval could also be simplified to improve access.

One example of how simplification could be achieved is by setting a financial limit (say $2,500) for certain types of treatment during the first 28 days (or longer period) following an accident. Claimants could obtain certain types of treatment up to the financial limit on an 'as needed' basis, without the hassle or stress of insurer oversight and simply apply for reimbursement at the end of that period. This would allow for speedier recovery of minor injuries, and also early intervention for more serious injuries. Claimants could be made aware of this entitlement as part of the CTP insurance premium renewal documentation sent by insurance companies.

Specific questions

5. Is the treatment and care being received by claimants appropriate for the nature and level of their injuries, and directed towards a return to work and other activities?

The Law Society submits that the treatment and care being received by claimants is not always appropriate for the nature and level of their injuries and is not directed towards a return to work and other activities in many cases. There is an inherent conflict between an insurer's statutory requirement to provide reasonable and necessary treatment and care and an insurer's desire to generate profits for its business and/or shareholders. This conflict can lead to denials of legitimate treatment and care requests.

An example which illustrates the conflict is a situation where an injured person has a pre-existing injury. If a person has previously had treatment for depression, but has been asymptomatic for a period of two years in the lead up to the accident, it is not uncommon for an insurer to dispute treatment for Post-Traumatic Stress Disorder ('**PTSD**'), stating that the claimant had a psychiatric condition which pre-dated the accident. The same situation exists with physical injuries. For example, if an injured person had a prior lumbar spine injury, which was asymptomatic for a period of two years, it is not uncommon for an insurer to deny treatment saying that the injury is pre-existing and not causally related to the motor accident.

In all of these scenarios, approving the treatment and assisting the claimant to return to work would yield far better outcomes than putting the claimant through a prolonged and litigious internal review and medical review process to attempt to establish the precise causal connection between the accident and the current injury manifestation. Some alternatives to these processes could include the removal of the need to seek internal review for treatment disputes and the introduction of a streamlined treatment dispute process which does not necessarily require the formal, and slow, medical assessment of the dispute by the Personal Injury Commission ('**PIC**').

6. Does determination of the relevant insurer under Sections 3.2 and 3.3 of the Act:
    (a) affect policyholders by delaying the receipt of the statutory benefits; or
    (b) work efficiently in all cases from the perspective of the injured person?

The Law Society submits that its members are largely satisfied with the manner in which the relevant insurer determinations are conducted. We note however that only a small number of our members have been exposed to such determinations. Those claimants who are self-represented are likely to have greater experience with problems of this nature. As such, we suggest that SIRA survey injured people who were subject to such determinations to obtain their feedback directly.

7. Section 3.25 of the Act provides that no statutory benefits are available for gratuitous attendant care services. Is paid care readily available to all who need attendant care?

Our members are conscious of the commercial reality that insurance companies need to have relationships with external businesses in order to facilitate the rehabilitation process. It is therefore unsurprising that most insurers appear to have a panel of rehabilitation provider companies that are used to assess the care needs of a claimant soon after an accident.

Our members have concerns that these rehabilitation providers quite often advocate and investigate on behalf of the insurer instead of remaining independent and providing balanced and independent assessments of paid care needs. Noting this background, it is not uncommon for paid care to be denied upon the recommendation of a rehabilitation provider, even in the immediate aftermath of an accident.

The Law Society's position is that greater oversight of this process is required to ensure that paid care is adequately delivered to all who need attendant care. Moreover, oversight will ensure that the benefits being costed in the CTP premium are actually being delivered.

8. Does Section 3.25 of the Act:
    (a) advance any of the objects of the Act; or
    (b) limit achievement of any of the objects of the Act?

The Law Society submits that Section 3.25 of the Act does not advance the objects of the Act. A motor vehicle accident is often a traumatic and life changing event. Claimants are stressed, confused and anxious and prefer to deal with people they are familiar with and trust, such as close friends and relatives. It is for this reason that gratuitous care will always be preferred by claimants, assuming that friends and relatives are in a position to provide such care.

The Law Society is of the view that, from a societal perspective, it is undesirable to be encouraging family members and relatives to bear the burden of unpaid attendant care, which frequently occurs in circumstances where the claimant, not unreasonably, does not wish a stranger to enter their home.

It should also be noted that the COVID-19 pandemic has added a further layer of stress and anxiety onto claimants. This can significantly impact a claimant's prospects of achieving optimum recovery by exacerbating their recovery time, both physically and psychologically.

The Law Society suggests that claimants should have the right under legislation to have close friends or family members perform paid care on their behalf in circumstances where they elect for that to occur rather than the provision of commercial care services arranged by the insurer.

Minor injury

The Law Society highlights that the minor injury threshold is one of the most contentious parts of the Scheme. The questions that have been asked as part of this review do not address the totality of the issues being faced by the Scheme. In addition to the issues raised in 9 and 10 below, we highlight the following other issues:

(i) In the experience of our members, insurers regularly make minor injury determinations following a cursory 'desktop' review. Insurers are commercial entities and therefore are not impartial adjudicators. This process is flawed, and can result in adverse outcomes both for the efficacy of the claims (and subsequent dispute resolution) process and for claimants, in terms of denial of statutory benefits and potentially common law damages. It is our strong suggestion that insurers must be required to clarify treatment evidence ambiguity with treating practitioners and allied health providers.

(ii) Currently, unless a dispute proceeds to the PIC, lawyers are not entitled to legal fees to advise an injured person on their rights and entitlements, including the process of establishing whether they have sustained a minor injury or not. As a consequence, injured people are often left without legal support. The Law Society supports the introduction of a fee, akin to that paid under the NSW Workers Compensation scheme, for an initial advice to be provided to a person injured in a motor vehicle accident to ensure appropriate access to justice.

(iii) Three months after the claim has been made, insurers are required to make a determination regarding whether the claimant has sustained a minor injury or not. There is no requirement in the Act, Regulation or Guidelines which compels an insurer to obtain evidence prior to making this determination, nor to clarify any ambiguity in the evidence that is obtained. Clause 5.6 of the Guidelines only requires the insurer to conduct an assessment of all evidence then available rather than requiring them to take any pro-active steps to obtain treating or medico-legal evidence. As a consequence, unjust and unfair outcomes can occur. The claimant can be left without any support for their injuries by way of treatment or care and also no support financially in the form of weekly payments.

If the claimant elects to dispute the decision, they must do so immediately, as payments cease for claimants who have sustained minor injuries 26 weeks after the accident. Claimants are also required under Clause 7.4 of the Guidelines to request an internal review from the insurer within 28 days. By the time the claimant gathers evidence, requests an internal review, obtains the outcome of the internal review, lodges a dispute with the PIC and awaits receipt of a reply from the insurer (or their legal representative) several months may have passed. This can mean that before the PIC has allocated a matter to a Medical Assessor, the claimant has already had their statutory benefits terminated. Current wait times for a medical assessment range from 6 to 12 months in the PIC as a result of the COVID-19 pandemic. Overall, it is not uncommon for a claimant to have to wait in excess of 12 months without financial support of any kind. The Law Society submits that, as in the Workers Compensation

scheme when disputes such as minor injury are challenged in the PIC, the insurer's decision should be stayed pending the outcome from the PIC.

9. Should the defined term 'minor injury':
   (a) be changed; and
   (b) if so, be 'short-term benefits injury', or another term?

The Law Society supports retaining the term 'minor injury', notwithstanding the various issues associated with it. General practitioners and allied health professionals have generally become familiar with the concept and to change the terminology now would only create more uncertainty with an already complicated concept.

A preferable approach would be to reconsider and reformulate the content of the minor injury definition to address the large number of disputes occurring within the Scheme.

10. Is the definition of 'minor injury' aligned with injuries (both physical and psychiatric or psychological) that are expected to resolve (or to stop improving with treatment and care) within the period that statutory benefits for treatment and care are available?

The Law Society submits that the current definition of 'minor injury' is not aligned with injuries (both physical and psychiatric or psychological) that are expected to resolve (or to stop improving with treatment and care) within the 26 week period that statutory benefits for treatment and care are available.

An important context for the development of the minor injury definition was the escalating whiplash claim trend that arose under the *Motor Accidents Compensation Act 1999* ('**1999 MAC Act**'). The 26-week cessation date enacted in legislation was purportedly a reflection of best practice medicine research for 'minor injury' recovery times.

However, a one size fits all model was legislated which fails to take into account three significant facts:

(i) Each claimant will react and recover from traumatic experiences differently. Best practice medicine is a guide to recovery and will not apply in all circumstances.

(ii) Compensation schemes are known for increasing recovery times of claimants.[1] Best practice medicine and the recovery times associated with them are formulated around people who are not involved in compensation schemes. It is therefore unreasonable to expect that a person who is involved in a compensation scheme will recover like a person who is not.

(iii) Many psychiatric injuries are time dependent and/or have a delayed onset of symptoms. As a consequence, if a person has sustained a significant psychiatric injury, it may not be able to be properly diagnosed less than six months post-accident, when an insurer is required to make a liability determination. Categorising all adjustment disorders as minor is at odds with the experience of our members that many claimants who suffer from a chronic adjustment disorder continue to suffer from significantly disabling symptoms years after the accident.

Given the above, it is clear that 26 weeks of statutory benefits can be inadequate for people who have sustained 'minor injuries' within the context of the Scheme. Greater consideration

[1] Genevieve M. Grant et al, 'Relationship between stressfulness of claiming for injury compensation and long-term recovery: A prospective cohort study' (2014) 71(4) *JAMA Psychiatry* 446, 450-452.

needs to be given to the individual real-life circumstances of the claimant to allow an extended period of recovery, to ensure that unfair and unjust outcomes are not commonplace.

We reiterate the position we put forward in 2016 and 2019 directly to SIRA, that instead of the current 'minor injury' definition, a 'narrative test' should be developed, which includes objective evidence of physical and/or psychological injury, but that does not rely solely on a number (for example, a WPI percentage). Instead, such a test should also consider the consequences of the injury on a person, and contain elements to the effect of:

> A permanent reduction in physical, psychosensory or intellectual potential that is the result of an anatomo-physiological injury:
>
> (a) 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 (e.g. MRI, x-ray, CT scan, etc), and
>
> (b) 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.

Further, our members would support an amendment to the minor injury definition that indicates that only DRE Category I spinal injuries and acute adjustment disorder are minor injuries. Currently, all forms of adjustment disorder (whether acute or chronic) and DRE Category II spinal injuries are included within the definition. Both chronic adjustment disorder and DRE Category II spinal injuries have recovery times far exceeding six months. Their exclusion is unwarranted if the definition of minor injury is in fact intended to be based on realistic recovery timeframes.

At-fault injured persons

11. Should statutory benefits for treatment and care for at-fault injured persons be limited compared to injured persons who are not at fault?

The Law Society agrees.

12. Having regard to the Objectives of the Act, why should they be limited, or why not?

The Law Society's position is that statutory benefits for treatment and care for at-fault injured persons should be limited in order to ensure that appropriate benefits are extended and increased for injured persons who are not at fault. The Law Society submits that this will assist in achieving objectives (a), (b) and (d). The Law Society recognises that there are finite funds available for benefits and, for the most part, they are better spent on those who have been injured through no fault of their own rather than on those who have caused the accident.

Further, redesigning the minor injury threshold and the way it is being implemented, along with removing the need for compulsory internal reviews, will give the existing cohort of claimants greater access to benefits.

13. If they should be limited, what should be the nature and extent of the limits?

The Law Society's position is that six months of benefits for at-fault injured people is adequate, taking into consideration that there are finite funds within a community funded compensation scheme.

14. If at-fault injured persons had the same entitlements to statutory benefits as persons not at fault (including weekly benefits), what would be the effect on the operation of the Scheme from the perspective of injured persons or other stakeholders?

The Law Society notes that it is a long entrenched societal view that injured people believe that if they are at-fault in a motor accident they have no entitlements. Those that do claim, tend to do so without a lawyer. When disputes arise, they become self-represented litigants relying on the dispute resolution system to guide them throughout the dispute resolution process. The lack of legal representation ultimately slows down the process, and the efficiencies that result from legal representation in a tribunal setting, simply do not accrue.

If increased numbers of at-fault people entered the Scheme, it is inevitable that disputes concerning minor injury, treatment and causation would increase. As timeframes for the cessation of benefits approach, it is foreseeable that insurer decisions regarding fault and liability would also be challenged in greater numbers.

The Law Society is concerned that with only 12% of insurer internal reviews for minor injury decisions resulting in a decision in favour of the claimant,[2] and extensive delays occurring in the PIC, particularly with regard to medical assessments, the Scheme's current framework is simply not equipped to handle the level of disputation that could occur.

The Law Society's members are also well aware of the frequently deleterious psychological impact on many claimants who have been injured by the negligent actions of another who is shielded from personal liability for his or her actions by the role of the insurer and who may also be receiving benefits for his or her injuries. This impact is likely to increase if treatment benefits and/or weekly benefits continue beyond 26 weeks for those at fault.

Objective (b)

To provide early and ongoing financial support for persons injured in motor accidents.

General questions

15. Does this objective remain valid?

The Law Society submits that this objective remains valid.

16. Are the terms of the Act, Regulations and Guidelines appropriate for securing this objective? If not, then in what respects and to what extent are those terms not appropriate for securing this objective?

The Law Society submits that the terms of the Act, Regulation and Guidelines have improved significantly when compared to the 1999 motor accidents compensation scheme in terms of securing this objective. There remains however, considerable room for improvement.

One such example can be found in Section 6.13(2) of the Act, which requires an injured person to lodge an Application for Personal Injury Benefits ('**APIB**') claim form within 28 days of a motor accident. Failure to do so results in a blanket loss of back dated weekly benefits. An injured person lodging an APIB after 28 days post-accident is only entitled to weekly payments from the date the APIB is lodged.

[2] State Insurance Regulatory Authority (n 9) 8.

Our members highlight there are a number of circumstances where this 28-day rule is oppressive. For example:

(i) A brain damaged injured person without family support who is unconscious for a period of time has no means of lodging an APIB.
(ii) A person injured in Queanbeyan taken to Canberra Hospital may be unaware of what compensation scheme to apply for (ACT or NSW). By applying to the right insurer but in the incorrect state, the claim may miss the 28-day timeframe.

In practice, the 28-day timeframe can result in unjust outcomes. The Law Society suggests that a mechanism for discretion be available for the insurer to accept a claim beyond the 28-day timeframe and to backpay wages. In circumstances where this is refused, the PIC should be given jurisdiction to order a back-payment of wages where the claimant has a full and satisfactory explanation for the delay in lodging the APIB.

17. What is the evidence that the Scheme is, or is not, achieving this objective?

Please refer to our response at 16.

18. What changes (if any) should be made for the Act, Regulations and Guidelines to secure, or better secure, this objective?

Please refer to our response at 16.

Specific questions

Weekly payments

19. Are the provisions governing the calculation of weekly payments working?

The Law Society's position is that the provisions governing the calculation of PAWE are not working and in practice, PAWE has become one of the most complex issues in the Scheme. This is evidenced by the number of matters before the court highlighting the complexity of the PAWE.

Allianz Australia Insurance Ltd v Jenkins (2020) 91 MVR 501
The judgment discusses the tax implications of the changing nature of the weekly benefit across the different entitlement periods. The judgment does not critique the method of calculating the PAWE but does highlight the complexity of this process noting that Weekly Benefits in the Third Entitlement Period, under Section 3.8 of the Act, are calculated on a net amount per week. Unlike the First and Second Entitlement Periods (Sections 3.6 and 3.7 of the Act) no PAYG Tax is remitted to the ATO in the Third Entitlement Period.[3]

ABS v AAMI [2021] NSWPICMR 23 (23 June 2021)
A recent PIC Merits Review dispute related to whether the claimant's PAWE was accurately calculated according to Div 3.3 of the Act, accounting for business losses and deductions, where the plaintiff was self-employed as part of a partnership. The Reviewer decided that a business' gross earnings must account for expenses to the business and any losses, as the Act does not define gross earnings.[4] The Reviewer noted that "the claimant is able to also deduct business losses from his individual income which provides a taxable income for the

[3] *Allianz Australia Insurance Ltd v Jenkins (*2020) 91 MVR 501, 508-509.
[4] *ABS v AAMI* [2021] NSWPICMR 23 (23 June 2021) [39]-[43].

particular year."[5] These comments highlight the complexity of calculating payable statutory benefits.

The impact of the COVID pandemic on reducing the earnings of claimants prior to the accident is another significantly complicating factor in PAWE calculations having regard to the terms of Clause 4(2) and 4(3) to Schedule 1 of the Act. Other problems arise because the term gross earnings in Clause 4(1) for self-employed persons has been interpreted by PIC Merit Reviewers to mean gross business income less business expenses. This causes difficulties for business owners who only get paid based on net business income yet are expected to absorb the cost of ongoing business expenses such as rent, insurance and wages.

The experience of our members is that payment entitlements are often miscalculated. Currently, the Scheme assumes that claimants will be able to determine the payments with the insurer's assistance. However, it is common practice that, due to the complexity of calculation, insurers engage forensic accountants to conduct the calculations. In the majority of circumstances claimants do not have the means or know how to instruct a forensic accountant to counter the insurer's forensic accountant report.

Further, we note instances of at least one insurer that has had significant issues relating to the calculation and payment of PAWE. However, SIRA's compliance reviews, and/or the penalties they have imposed, are not publicly available. We suggest that SIRA should be required to publish all regulatory determinations and penalties in a central, easily accessible place. This would enhance Scheme transparency and also result in better outcomes for claimants.

20. Are there amendments consistent with the objects of the Act that would result in fewer disputes or earlier determination of the correct weekly payments?

Noting the disparity of resourcing available to insurers vis-a-vis claimants, the Law Society submits that legal representatives should be able to assist claimants with PAWE and weekly payment disputes and should be entitled to legal fees for those services.

The Law Society is of the view that the current definition of PAWE is complex. If the PAWE system is intended to enable claimants to navigate without assistance, greater clarity must be provided in respect of how PAWE is calculated. This can be done through an easily accessible directory of PAWE decisions and/or including numeric formulas in the Act for insurers and claimants to apply to the First, Second and Third entitlement periods (Sections 3.6 to 3.8 of the Act).

Cessation of weekly payments

21. Should weekly payments only continue beyond 2 years if the person's injury is the subject of a pending claim for damages?

Currently, weekly payments of statutory benefits only continue beyond two years if a claimant's injury is the subject of a pending claim for damages. This fails to take into consideration disputes regarding minor injury which determine whether an entitlement to damages exists and to what extent.

As previously mentioned, there are considerable delays in the PIC as a consequence of the COVID-19 pandemic. It is not uncommon for claimants to be waiting for 12 months without financial support whilst their minor injury dispute is waiting for determination in the PIC.

[5] Ibid [42].

The Law Society submits that weekly payments should continue beyond six months, and also two years, if a dispute is presently before the PIC to determine the extent of the claimant's injuries.

22. Should the position be different if there is no one at fault (i.e. a claim by an injured driver in single-vehicle no-fault accident)?

The Law Society submits the position should not be different if there is no one at fault. If a dispute is before the PIC to determine the extent of an injured person's injury, the injured person should be entitled to ongoing weekly payments.

Gratuitous attendant care

23. Should a person who provides gratuitous attendant care services be reimbursed for losses incurred as a result of providing that care?

Yes, please refer to our response at 7.

Minor injury

24. Should the period for which weekly benefits are available for persons with only 'minor injuries' be longer than 26 weeks?

The Law Society submits that the period for which weekly benefits are available for persons with only 'minor injuries' should be longer than 26 weeks, however extended only to persons who are not at-fault. Please refer to the issues raised in 10 above with regard to recovery times of injured people within compensation schemes.

25. If so, for what period should weekly benefits be available for persons with only 'minor injuries'?

The Law Society submits that weekly benefits should be made available for persons with only 'minor injuries' for a period of 12 months. As such, the corresponding decision for liability should also change from three months to up to nine months. This will allow for psychiatric injuries suffered by the person to fully develop and be treated and diagnosed with accuracy. Currently, insurers are rejecting claims because injuries such as PTSD cannot be diagnosed at three months.

As stated earlier, the Law Society would also support a continuation of weekly benefits in circumstances where a claimant disputes the minor injury determination in the PIC, while that dispute is ongoing.

Damages

26. Should an injured person with permanent impairment <10% be required to wait 20 months (or some other period) before making a damages claim?

The Law Society submits that an injured person with permanent impairment less than or equal to 10% should not be required to wait 20 months (or some other period) before making a damages claim.

We understand that the primary intention of the 20-month rule is to allow an increased recovery time for injuries. We submit that this logic is counterintuitive when the Scheme has already removed 'minor injuries' 26 weeks after the date of the accident as a consequence of the minor injury definition.

In our view, this threshold is an unnecessary impediment which contradicts Section 1.3(2)(g) of the Act which is to 'encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes.' We therefore query why the 20-month claim lodgement timeframe is required.

27. Does the 20-month period align with any of the objects of the Act?

No, the Law Society considers that the 20-month rule is an unnecessary friction point in the Scheme.

The 20-month delay before an insurer is formally notified of a damages claim also has a delaying factor on the readiness of the matter to proceed to a damages settlement or assessment. This is because an insurer typically does not commence investigations of the claim (including medical assessments) until they have received formal notification of a damages claim. Given the limited timeframe of three months within which the insurer is required to respond to service of a damages claim, it should be unsurprising that our members are aware of incidents where there has been some delay occasioned by insurers ensuring all medico-legal and other evidence is collated before the claim is assessed.

Many of our members have expressed concern that insurers refuse to make a decision about whether the injured person exceeds the 10% permanent impairment threshold, as it also means that the insurer is conceding that an entitlement to non-economic loss exists. As a consequence, insurers may frustrate the process by not responding or indicating that insufficient information exists to determine the extent of the injured person's injuries. This course of action means that a greater proportion of disputes are lodged with the PIC and, as a consequence, significant delays are occurring with the resolution of claims due to the COVID-19 pandemic as matters cannot be promptly referred for determination to a Medical Assessor.

28. Does the 20-month period:
    (a) encourage early resolution of claims?

No, the Law Society submits that the 20-month period actively delays the resolution of claims unnecessarily. Please refer to our response at 26 and 27.

    (b) deter injured persons from making damages claims?

Yes, the Law Society submits that many injured persons become frustrated and abandon their entitlements, even with legal assistance. Abandonment can only be measured by SIRA comparing people who pursue an APIB claim, have an entitlement to damages, but who do not pursue it/obtain a financial outcome as part of a damages claim.

    (c) effectively deter fraud?

We note that SIRA reported the 1999 MAC Act scheme was significantly beset by small claims, and that the increased frequency of these claims resulted in the introduction of a ban on referral fees associated with compensation claims and a $50,000 legal fee contracting-out cap.

When the 2017 Scheme was subsequently enacted, various mechanisms were included in the Scheme to remove the frequency of these claims, including:

i. a $75,000 legal fee cap,
ii. a minor injury threshold, and

iii. a 20-month restriction on common law claim lodgements for people with injuries assessed at 10% permanent impairment or less.

We submit that the 20-month restriction on common law claim lodgement (and the associated 2-year restriction on damages claim settlements) is not having any impact on fraudulent claim lodgement and should therefore be removed.

29. Does the 20-month period benefit:
    (a) injured persons;

No – please refer to our response at 26, 27 and 28 above.

    (b) insurers; or

No, the Law Society submits that delaying claims means claim reserves are held for longer, which has a flow on effect to the amount of capital that insurers are required to hold. In a low interest yield environment, where profits are limited by SIRA, it is in an insurer's interest to resolve claims in a shorter timeframe. Thus, shortening the 'long tail' nature of the Scheme is in an insurer's best interest.

Resolving claims earlier allow for insurers to realise profits in a shorter timeframe. Retaining the 20-month timeframe serves limited benefit to insurers.

    (c) policyholders by having a material effect on premiums?

No, the Law Society submits that the 20-month period has no positive impact on the price of premiums. Extending the long tail nature of the Scheme means that insurers have to hold reserves for longer. This comes at a cost as claims tend to increase in size, the longer their duration extends. As a result, increased claim size has a negative impact on premium price as it increases cost.

Noting that the rationale for the 20-month rule is to allow for 'maximum recovery' (see question 30 below), it is important to remember that people with 'non-minor' injuries are being compensated for permanent injuries. Maximum recovery should not be mistaken with a complete recovery.

30. To the extent that the rationale for the 20 month waiting period is to allow maximum recovery from injury before damages are claimed, how does that rationale only apply to persons with permanent impairment <10%?

The Law Society submits that this is inconsistent with Section 1.3(2)(g) of the Act, which is 'to encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes'.

The purpose of the minor injury threshold is to exclude people who sustained injuries which would resolve within six months and to prevent them from obtaining compensation. Given this, it is difficult to maintain that the 20-month damages claim lodgement rule has any effect on maximum recovery from injury. People who have 'non-minor' injuries are entitled to be compensated and should not have to wait 20 months to pursue a damages claim. Quite often these claimants are only claiming a percentage of past economic loss not compensated under the statutory benefits regime and the associated tax paid by the insurer (*Fox v Wood*[6]). Rehabilitation of injury has no bearing on these benefits in the majority of cases as the weekly wages were paid for a closed period and the injured person has already returned to work.

[6] (1981) 148 CLR 438.

31. If the 20 month period was removed or replaced with a shorter period, would any other changes to the Scheme be needed?

The Law Society submits that removal of the 20-month period would also require the removal of the 2-year prohibition on settling claims contained within Clause 6.23(1) of the Act.

Objective (c)

To continue to make third-party bodily insurance compulsory for all owners of motor vehicles registered in New South Wales.

General questions

32. Does this objective remain valid?

The Law Society continues to support compulsory third-party bodily insurance for all owners of motor vehicles registered in New South Wales.

33. - 35.

The Law Society is not aware of any difficulties with the provisions of the Act, Regulations and Guidelines in securing this objective.

Objective (d)

To keep premiums for third-party policies affordable by ensuring that profits achieved by insurers do not exceed the amount that is sufficient to underwrite the relevant risk and by limiting benefits payable for minor injuries.

General questions

36. Does this objective remain valid?

The Law Society does support maintaining premiums for third-party policies at an affordable level. However, this should not be at the expense of other priorities, including the principles of fairness and accessibility to dispute pathways for injured claimants.

37. Are the terms of the Act, Regulations and Guidelines appropriate for securing this objective? If not, then in what respects and to what extent are those terms not appropriate for securing this objective?

Questions of premium regulation, risk equalisation and profit regulation are not within the areas of expertise of the Law Society's members.

38. What is the evidence that the Scheme is, or is not, achieving this objective?

The question of whether insurer’s profits have been kept at a level which does not exceed the amount that is sufficient to underwrite the relevant risk is a matter for actuarial analysis and beyond the expertise of our members.

However, the Law Society does note that there are strong indications in Scheme performance to date to suggest that premiums are being kept at extremely affordable levels. The latest information on the SIRA open data portal as at 19 July 2021 says that the average premium

is now only $485.[7] Against any measure of affordability, the Law Society submits that premiums are now very affordable. For instance, this amount sits comfortably below the figure of $526 which was used by the Scheme actuary as the Scheme annual premium rate at the outset of the 2017 Scheme.

If the limitation on benefits for "minor injuries" was intended to keep premiums affordable, then the Law Society submits that the minor injury test has gone too far. The latest figures published on the SIRA open data portal as at 19 July 2021[8] state that 19,388 claimants have been assessed as suffering from a minor injury out of 35,090 claimants who have been assessed for the minor injury test. That is, around 55% of injured claimants have been assessed as suffering from a minor injury. These claimants have been deprived of the right to any ongoing statutory benefits beyond 26 weeks and they have been deprived of the right which would otherwise have been available to them to pursue a damages claim for their injuries. The Law Society submits that amendments should be made to the minor injury definition as detailed in our 6 September 2019 SIRA Submission and 9 November 2020 SCLJ Submission, both of which are **attached** and reiterated in 10 above.

39. What changes (if any) should be made for the Act, Regulations and Guidelines to secure, or better secure, this objective?

The Law Society submits that the minor injury test should be amended in accordance with the submissions the Law Society has previously made both to the SIRA Minor Injury Review and to the 2020/2021 Review of the Compulsory Third Party Insurance Scheme by the Standing Committee on Law and Justice as reiterated in 10 above.

The Law Society makes no submission on measures to curtail insurer profits other than to note that in terms of premium affordability the Scheme has more than 50 areas of potential dispute. There are numerous friction points within the Scheme, such as whether a person has sustained a minor injury or a non-minor injury or whether the claimant was wholly or mostly at fault. The more friction points within any third-party system, the greater the risk of the Scheme becoming less affordable. Accordingly, the Law Society questions whether there does need to be as many dispute categories creating friction points as currently exist.

Specific questions

40. – 42.

Other stakeholders are better placed to comment in this regard.

43. The profit regulation provisions in the Act require that excess profits returned by insurers be used to fund reductions in the cost of CTP insurance. An alternative that has been suggested is to use the excessive profits to fund road-related initiatives, thus effectively converting the excess profits into government revenue to be used for specific purposes. Should SIRA have the power to use excess profits returned by insurers in this way?

The Law Society submits that any excess profits returned by insurers should be taken into account in expanding the benefits currently available to injured claimants rather than being applied to other road-related initiatives. Further, or in the alternative, these returned profits should be used, at least in part, to fund the expansion of the current Independent Legal Assistance and Review Service ('**ILARS**') scheme for funding legal costs in workers compensation claims to funding legal costs in statutory third-party claims, as recommended

[7] State Insurance Regulatory Authority, *2017 CTP Scheme Open Data* (Web Page) <https://www.sira.nsw.gov.au/CTP-open-data>.
[8] Ibid.

by the Standing Committee on Law and Justice. The Law Society reiterates that issues with access to justice and fairness in delivery of benefits to injured claimants should be higher priorities within the 2017 Scheme than they are at present and the return of excess profits offers an opportunity to fund, at least in part, the cost of their elevated priority.

44. Should Section 2.25 of the Act be amended to align more closely with the way that insurer profits are regulated under Part 2 of Schedule 4 of the Act?

Other stakeholders are better placed to comment in this regard.

Objective (e)

To promote competition and innovation in the setting of premiums for third-party policies, and to provide the Authority with a role to ensure the sustainability and affordability of the compulsory third-party insurance scheme and fair market practices.

General questions

45. Does this objective remain valid?

The Law Society agrees that this objective remains valid.

46. Are the terms of the Act, Regulations and Guidelines appropriate for securing this objective? If not, then in what respects and to what extent are those terms not appropriate for securing this objective?

Other stakeholders are better placed to comment in this regard.

47. What is the evidence that the Scheme is, or is not, achieving this objective?

The Law Society does not have sufficient experience of, or expertise in, these matters to usefully pass comment other than to draw to the attention of the consultants the answers provided by SIRA to questions 29 to 35 of the questions on notice posed to SIRA by the Standing Committee on Law and Justice following the hearing on 26 May 2021.[9] These questions and answers suggest that SIRA has yet to explore its full powers of regulatory compliance with insurers to date.

48. What changes (if any) should be made for the Act, Regulations and Guidelines to secure, or better secure, this objective?

Other stakeholders are better placed to comment in this regard.

Specific questions

49. – 55.

Other stakeholders are better placed to comment in this regard.

[9] Standing Committee on Law and Justice, Parliament of New South Wales, *2020 Review of the Compulsory Third Party insurance scheme* (State Insurance Regulatory Authority (SIRA) Answers to Questions on Notice, 21 June 2021).

Objective (f)

To deter fraud in connection with compulsory third-party insurance.

General questions

56. Does this objective remain valid?

The Law Society submits that objective (f) remains valid, noting however that the issue of fraud has been adequately addressed in the Scheme.

57. Are the terms of the Act, Regulations and Guidelines appropriate for securing this objective? If not, then in what respects and to what extent are those terms not appropriate for securing this objective?

As noted above at 28, SIRA reported that the 1999 MAC Act scheme was significantly burdened by small and potentially fraudulent claims. The Law Society submits the anti-fraud measures have in fact over-delivered on securing this objective. The $75,000 cap on 'contracting out' of solicitor/client costs should either be reduced or eliminated, the 20-month waiting period for damages claim should be removed and the harsh effects of the minor injury definition should be ameliorated.

58. What is the evidence that the Scheme is, or is not, achieving this objective?

The Law Society relies on recent reports noting that SIRA is working with NSW Police and other bodies in relation to fraudulent claims.[10] As of June 2020, there were 29,753 claims of fraud and, of those claims, the report notes that 35 arrests were made from April 2017 to June 2020, and 209 charges laid.[11] These numbers suggest that fraud is actually not as significant an issue as was considered before the introduction of the 2017 CTP Scheme.

The Law Society notes that, in an effort to compare to the previous 1999 Scheme, the last performance report available[12] on the previous scheme does not address the topic of fraud.

59. What changes (if any) should be made for the Act, Regulations and Guidelines to secure, or better secure, this objective?

The Law Society submits that without proper and detailed analysis of the numbers addressing the effective deterrence of fraud, it is difficult to determine what, if any, changes should be made. The Law Society's position is that resources would be better applied to assisting claimants navigate their way around a complex scheme, particularly for those claimants without legal representation.

Specific questions

60. To what extent have each of the following aspects of the legislative framework been effective in deterring fraud in connection with the CTP Scheme?

---

[10] State Insurance Regulatory Authority, *CTP scheme performance report 2020 - Motor Accident Injuries Act 2017* (Report, May 2021) <https://www.sira.nsw.gov.au/__data/assets/pdf_file/0004/984604/2017-CTP-Scheme-Performance-Report-2020.pdf>.

[11] Ibid 14.

[12] State Insurance Regulatory Authority, *NSW CTP Scheme performance report 2019-20 – Motor Accidents Compensation Act 1999* (Report, 2021) <https://www.sira.nsw.gov.au/__data/assets/pdf_file/0005/984614/CTP-Scheme-1999-Scheme-Performance-Report-2019-2020.pdf>.

(a) the 'minor injury' framework?

As noted above, in our view, the ‘minor injury’ framework has been over-effective in reducing the available support for claimants with ‘minor’ injuries.

(b) the penalties for fraud?

Without the comparative data mentioned above, it is difficult to say whether the penalties are effective in deterring fraud.

(c) SIRA's power to investigate claims to detect and prosecute fraud?

Without the comparative data mentioned above, it is difficult to say whether the investigative powers are effective in deterring fraud.

(d) the obligations on insurers to take steps to deter and prevent the making of fraudulent claims, and apply the principle of detecting and deterring fraud across all claims management aspects for the life of a claim under the Scheme?

Without the comparative data mentioned above, it is difficult to say whether the obligation on insurers is effective in deterring fraud. Although the volume of prosecutions compared to the volume of open claims under the Scheme is a KPI of this objective, a better measure may be the number of claims withdrawn from the Scheme. There is a requirement on the insurer to provide data on the reasons for said withdrawals, and the data should be published in an expedited manner by SIRA.

61. Are there additional elements that should be introduced into the framework for securing Objective (f)?

In the interests of avoiding further complexities and requirements which are likely to merely cause more delays in the Scheme, the Law Society does not submit any additional elements to secure Objective (f). As mentioned above, resources should be directed at assisting claimants to navigate the Scheme and to understand the processes as well as their entitlements.

62. Should the obligations on insurers in relation to deterring fraud be more prescriptive?

Please refer to our response at 61.

63. Are changes to the Scheme needed with respect to:
    (a) misreporting of CTP claims?
    (b) the consequences for those who do not take out the correct policy?
    (c) the consequences for those who engage in any dishonest activity to obtain (or assist another person to obtain) a benefit under the Scheme?

The Law Society submits that no changes are required to the Scheme in this regard, other than noting that there needs to be an increase in SIRA’s resources geared towards more active monitoring of insurers’ correspondence with claimants about their entitlements, especially given many claimants experience language difficulties and/or other disadvantages that cause them to struggle with the complexities of the Scheme – particularly with respect to time limits, obligations, and entitlements to review. This is especially important where legal representation is limited.

Objective (g)

To encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes.

General questions

64. Does this objective remain valid?

The Law Society submits that this objective remains valid.

65. Are the terms of the Act, Regulations and Guidelines appropriate for securing this objective? If not, then in what respects and to what extent are those terms not appropriate for securing this objective?

No, it is the experience of our members that aspects of the Act provide mechanisms that can delay the quick, cost effective and just resolution of disputes.

Section 6.20 of the Act provides an insurer a second opportunity to determine a claim at the time the injured person makes a claim for common law damages. This second opportunity provides the insurer a three-month window within which to advise the claimant whether liability is admitted for his or her common law damages claim. Although Section 6.20(1) provides that the insurer "*must as expeditiously as possible*" give its liability notice to the injured person, in the experience of our members, the liability decision can be delayed beyond the 90-day period.

This delay until the end of the three-month period is against the background of an injured person being unable to make a claim for damages before the expiration of 20 months after the accident, and the requirement that proceedings be lodged in the PIC within three years of the accident. Therefore, even assuming the injured person's solicitor has been most efficient in his or her preparation of the matter, the delay may lead to injured persons running out of time to commence proceedings within three years.

As noted above, the 20-month delay before an insurer is formally notified of a damages claim also delays the readiness of the matter to proceed to a damages settlement or assessment. We also note that Section 6.23 of the Act (which prevents any settlements within two years of the motor accident unless the claimant's whole person impairment is greater than 10%) creates additional unnecessary delays. This provision prevents parties from settling a claim, or even meaningfully discussing settlement of a claim, until a further four months have passed after the damages claim has formally been made. Noting that Section 6.22 of the Act only requires an insurer to make a reasonable offer of settlement "*as soon as practicable"*, we consider Section 6.23 discourages prompt settlement discussions.

66. What is the evidence that the Scheme is, or is not, achieving this objective?

In addition to 65 above, it is our members' experience that irrespective of the severity of a claimant's injury, our members are rarely seeing concession of greater than 10% WPI since the Scheme began on 1 December 2017. It is common knowledge that there are very significant delays in determination by the PIC of both minor injury and treatment disputes currently averaging at about 8-9 months.

67. What changes (if any) should be made for the Act, Regulations and Guidelines to secure, or better secure, this objective?

The Law Society submits, for reasons given above, that consideration needs to be given to the redrafting or removal of Section 6.14(1), removing the 20 months waiting period. The Law Society submits that the 20-month period be reduced to 12 months or that the waiting period be entirely removed.

In addition to the issues raised above, the Law Society submits that consideration be given to the amalgamation of the claimant's current requirement to submit two application forms for statutory entitlements and common law damages, respectively. A preferred process would allow the claimant to make only one application to an insurer for both common law and statutory entitlements where the onus is on the insurer to review the claim within a designated period of time (say, 12 months) and make a determination on whether the claimant is able to receive common law damages in that time. There should be a mechanism whereby the insurer actually prompts the claimant to pursue common law damages and trigger this process, accelerating a claimant's common law rights. That is, if a claimant gets through the minor injury threshold and is not at fault, the insurer should then automatically be required to assess liability for common law damages, rather than waiting for a new claim form to be submitted. This removes the unnecessary requirement of a 20-month wait before a claimant can pursue common law damages and will accelerate the progress of a claim dramatically.

In order to reduce the delays with medical assessments at the PIC the Law Society submits that the Guidelines be amended to further clarify and incentivise the joint medico-legal assessment process.

Specific questions

Time limits

68. Does the loss of statutory benefits in respect of the period before a claim submission, if the claim is submitted more than 28 days after the motor accident concerned, help to secure Objective (g)?

No, the Law Society submits that loss of statutory benefits in respect of the period before a claim submission if the claim is submitted more than 28 days post-accident, is inconsistent with objective (g).

The Law Society's position is that this is not a just resolution of the dispute. The claimant may have a good claim for statutory benefits, but if the claim is not submitted within 28 days of the accident, the injured person loses the ability to claim for the first 28 days after the accident, under any circumstances. This is punitive and harsh as there is no mechanism for relief for a claimant even if the deadline is missed through no fault of the claimant, as explained at 16 above.

A just resolution of the dispute could be achieved if the injured person was able to make a claim for statutory benefits for the first 28 days, even if the claim was made after 28 days of the accident, if a "full and satisfactory explanation for the delay" was provided.

69. If not, does it help to secure any other Objective of the Act?

No, and certainly not Objectives (a), (b), (f).

70. How do insurers apply the objective test required for a 'satisfactory' explanation for a failure to comply with a duty?

In the experience of our members, insurers have been applying the test narrowly.

71. Should the test be aligned with the test required for a 'satisfactory' explanation for delay?

Yes, the test should be amended with words to the effect that a “reasonable person in the position of the Claimant would have been justified in failing to comply”.

72. Are there changes to the provisions in the Act governing the timing of steps in the making and resolution of claims that could better secure Objective (g)?

Please refer to our response at 67 and 68 in relation to the making of claims.
Please refer to our response at 65 in relation to the resolution of claims.

Internal review

73. In what ways does the internal review framework help or hinder Objective (g)?

The Law Society’s position is the internal review framework hinders Objective (g) as it applies to resolving minor injury and insurer liability decisions as well as prohibiting legal fees for claimant lawyers providing advice at the internal review stage. The latest figures the Law Society has access to, published by SIRA in March 2021, indicate that only 12% of insurer internal reviews of minor injury decisions resulted in a decision in favour of the claimant.[13] In these circumstances, we query the utility of the internal review process, at least in relation to minor injury decisions by insurers.

One mechanism to encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes would be to remove the requirement for claimants to seek an internal review of an insurer’s liability decision before progressing to the PIC. We note, based on the statistics SIRA has provided in June 2020 that 29% of insurer decisions on fault are overturned on internal review, while 66% of insurer internal review decisions on fault were overturned by DRS.[14]

Noting these statistics, and that the internal review process often leads to delays, we consider the legislation should be amended to give a claimant a choice to proceed straight to the PIC for a review of the liability decision, rather than requiring the claimant to engage with this process first.

Further, we suggest that provision be made for claimant lawyers to receive a fee for legal assistance in respect of internal reviews even if a dispute does not proceed past the internal review point. In our view, this is likely to assist in the early resolution of disputes and would therefore assist with the PIC’s workload. We provide more detail on this point in our response to question 81.

In addition, the Law Society considers that possible explanations for the statistics in respect of overturning insurer internal review decisions include the number of errors made by an insurer. In our members’ experience, this is due in large part to the lack of legal expertise and understanding of the law on the part of a reviewer. These internal factors can be resolved by an insurer providing reviewers with regular professional education. The Law Society also concedes there are external factors that are beyond the insurer’s control, such as the presence of additional information which has changed the outcome of the decision. However, if new information is provided to the insurer either at the post internal review stage or at the PIC

[13] State Insurance Regulatory Authority (n 9) 8.
[14] State Insurance Regulatory Authority, *CTP Insurer Claims Experience and Customer Feedback Comparison* (Report, 30 June 2020) <https://www.sira.nsw.gov.au/__data/assets/pdf_file/0004/909256/CTP-insurer-claims-and-experience-and-customer-feedback-comparison-June-2020.pdf>.

stage, the Law Society's position is that the insurer should take a more proactive approach, constantly review the decision and make the right decision upon the receipt of the relevant new documents. This is already in the Guidelines, although it is unclear how often it occurs in practice.

74. Are changes needed to the internal review framework to better secure Objective (g)?

The Law Society submits that the internal review framework should be removed entirely, allowing claimants to proceed directly to the PIC.

75. How often and for what reasons do insurers consult their in-house lawyers in connection with applications for internal review?

For the majority of decisions, it is our members' experience that insurers do not generally seek in-house legal consultation, noting that it is often the case that the internal review team is focused on customer relations and is separate to the in-house legal team.

Independent review

76. Should the Act provide in any circumstances for a stay of an insurer's decision to stop or reduce an injured person's statutory benefits, if the claimant applies for a review of the decision?

The Law Society's position is the Act should be amended to enable a stay of an insurer's decision on earning capacity or minor injury, pending a PIC assessment. We note this is available in the Workers Compensation scheme, under Section 289B of the *Workplace Injury Management and Workers Compensation Act 1998* and consider that a provision along those lines may enhance access to justice for claimants under the Scheme.

We also consider that the Act should provide for a stay when there is a dispute as to whether the claimant is wholly or mostly at fault. In our members' experience, some insurers appear to apply unreasonably high levels of contributory negligence, without understanding that they bear the onus of proving who is wholly or mostly at-fault. During the dispute, a claimant can be cut off from their statutory benefits after 26 weeks leaving many claimants without monetary or treatment support.

77. To what extent to do insurers rely on their in-house lawyers in matters before the PIC, a merit reviewer or medical assessor?

Other stakeholders are better placed to respond to this question.

78. Subdivision 3 of Division 7.6 of the Act, which governs miscellaneous claims assessments, is complex as a result of incorporating the terms of Subdivision 2 subject to a range of amendments set out in the Regulations. Bearing in mind the restrictions on legal advice, would claimants be assisted if the relevant terms were simply set out in Subdivision 3 and, if so, should that be done?

Yes, in our view the wording of the section number is confusing and should be amended. In particular, Section 7.42 and especially subsection (2) should be amended, as it is heavily modified by Regulation 17. As currently drafted, it states what is excluded, by Regulation 17. In our view, it would be more useful for this provision to be redrafted to express what is included.

Medico-legal assessments and legal assistance

79. Are there improvements to the system of 'Authorised Health Practitioners' that would help to secure Objective (g)? If so, what improvements?

The Law Society is of the view that the 'Authorised Health Practitioners' ('**AHP**') system does not have a practical impact in relation to the quick, just and cost-effective resolution of a claim.

We understand that the intention behind the AHP scheme was to remove from the system those report writers whose opinions typically heavily favour either a claimant or insurer. The existing AHP system requires doctors to take positive steps to become accredited health providers while at the same time capping the maximum fee chargeable (currently $1,660). The practical effect of the AHP system has been to significantly reduce the pool of AHPs being available to the parties, particularly in areas of specialty such as neurosurgery or neurology where complex opinions are required. The Law Society has also yet to see evidence that the AHP system has successfully removed 'outlier' report writers whose opinion is heavily slanted towards one party.

80. If the system of 'Authorised Health Practitioners' were abolished, what should replace it?

The Law Society rejects the proposition that a qualified medical practitioner must take positive steps to secure approval for writing reports. This imposes unnecessary hurdles and makes it more difficult to obtain a medico-legal opinion in a more complex medical case within the capped legal costs rate of $1660. The Law Society supports a system where it is not necessary for a specialist to "opt in" to the report writing system but where SIRA retains the power to discipline outliers in a procedurally fair way. This power already appears as part of the proposed amendment to Part 3, Division 3 of the *State Insurance and Care Governance Act* (Section 26D) which forms part of the *Motor Accidents and Workers Compensation Legislation Amendment Bill 2021* currently before the NSW Parliament.

81. Do the provisions restricting access to paid legal advice in connection with claim disputes help to secure Objective (g)?

As noted earlier in this submission, claimant lawyers do not receive a fee if a dispute does not proceed past the internal review point, even where they have done a significant amount of work which has resulted in an insurer overturning the original decision. We are concerned that, as a result, more disputes proceed to the PIC for review when, if appropriately resourced, claimant lawyers may be more successful in helping to resolve the matter during the initial stages of the process. We suggest provision be made for recovery of costs by claimant lawyers for advice or services provided at any stage of the review process.

It is our members' experience that most claimant solicitors tend to avoid incurring disbursements in relations to obtaining pre-accident clinical records until the matter is eligible to be referred to the PIC for assessment, where legal fees and disbursements are recoverable. This is particularly relevant in matters regarding aggravation of pre-existing conditions. If claimant solicitors were to have access to ILARS funding in the motor accident Scheme, this would incentivise early and thorough investigation of claims with relevant documents being submitted to the insurer at the internal review stage. The certainty that costs for all services can be recovered facilitates earlier provision of advice to claimants on their prospects of success. Unmeritorious referrals to the PIC will be less likely to occur and PIC assessors will have greater capacity to assess other claims and provide a faster turnaround time for meritorious claims.

CTP Assist

82. How should CTP Assist recognise and support the role of carers who provide decision-making support to injured persons?

The Law Society suggests that CTP Assist should recognise the role of carers who provide decision-making support to injured persons by including them in the telephone calls that provide advice to the injured person.

Insurers as decision-makers

83. Could the Scheme better secure Objective (g) if an independent person (as inquisitor) were appointed to decide the existence or otherwise of facts governing liability to pay statutory benefits?

The Law Society agrees with the appointment of an independent inquisitor and welcomes further consultation on this proactive approach.

84. If so:
    (a) who would be the decision-maker?

The Law Society suggests a list of inquisitors who would replace the internal review officers from within insurers, so that the independent review will be conducted by individuals appointed by SIRA as opposed to being appointed by the relevant insurer. The inquisitor should be an experienced motor accidents lawyer who fulfils the criteria for accreditation. Such criteria should be devised in consultation with the relevant legal professional associations.

    (b) what role, if any, would insurers have in the inquisitorial process?

The insurer should provide a short document highlighting:
i. the nature of the dispute;
ii. the documents which they relied on in making the decision; and
iii. a list of all documents that are in their possession.

    (c) what rights, if any, would insurers have to seek review of the decision-maker's decision?

If there is a material error or additional relevant information, the insurer should be allowed the opportunity to refer the inquisitor’s decision to the PIC for consideration.

Objective (h)

To ensure the collection and use of data to facilitate the effective management of the compulsory third-party insurance scheme.

General questions

85. Does this objective remain valid?

The Law Society continues to support the collection and use of data to facilitate the effective management of the Scheme.

86. Are the terms of the Act, Regulations and Guidelines appropriate for securing this objective? If not, then in what respects and to what extent are those terms not appropriate for securing this objective?

The Law Society would welcome greater transparency from SIRA in this area, but otherwise notes that other stakeholders are better placed to comment in this regard.

87. What is the evidence that the Scheme is, or is not, achieving this objective?

Other stakeholders are better placed to comment in this regard.

88. What changes (if any) should be made for the Act, Regulations and Guidelines to secure, or better secure, this objective?

Other stakeholders are better placed to comment in this regard.

Specific questions

89. Should the Act or Regulations prescribe particular data that must be collected or publicised by SIRA or insurers, or particular uses to which SIRA or insurers must put certain data, in addition to such obligations that already exist?

The Law Society continues to be concerned about the lack of data currently available as to what happens to those with "minor" injuries who exit the Scheme after 26 weeks. For instance, the SIRA Minor Injury Report published in February 2020 says that 70% of labourers have returned to work after 26 weeks.[15] The Law Society queries what has happened to the 30% of labourers suffering from a minor injury who have not returned to work after 26 weeks. There is simply no analysis of what has happened to these workers. In our view, this data is necessary to properly evaluate the success of this aspect of the Scheme.

Implementation (KPI analysis)

In relation to each Objective:

(a) Are the proposed KPIs adequate for assessing the implementation of the Scheme objectives? If not, what other measurable KPI(s) could be included for each Scheme objective, and why do you view these as important? Please include any supporting evidence.
(b) Should any of the proposed KPIs be amended to improve the assessment of the implementation of the Scheme Objectives? If so, please propose amended wording for the relevant KPI.
(c) Please select two (2) out of the proposed KPIs for each Scheme objective you view are most important in assessing the implementation of each Scheme objective and provide your reasoning.

[15] State Insurance Regulatory Authority, *Review of Minor Injury Definition in the NSW CTP Scheme* (Final Report, February 2020) <https://www.sira.nsw.gov.au/__data/assets/pdf_file/0005/600737/Review-of-Minor-Injury-Definition-in-the-NSW-CTP-Scheme-report.pdf>.

Objective (a)

Sub-objective a.1: To encourage early treatment and care to achieve optimum recovery of persons from injuries sustained in motor accidents.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY SUBMISISON
CLAIM ACCEPTANCE RATES	The rate of statutory benefits claims accepted by insurers.	This is not indicative of whether early treatment is received. Treatment is not determinative of whether a claim is accepted.
TIMELINESS OF CLAIM REPORTS	Percentage of claims reported within 28 days after the accident date.	This is not indicative of whether early treatment is received. Timeliness of claim is different to timeliness of request for treatment.
TIMELINESS OF LIABILITY DECISIONS	Percentage of claims with less than a 28 day interval between the date the claim is reported and the date the liability decision is made.	As treatment can be paid for before a liability decision is made, this KPI would be better worded “Timeliness of first payment of treatment”.
TREATMENT BEFORE A CLAIM IS MADE	Percentage of claims with less than a 28 day interval between the accident date and the date of first treatment.	Agreed.
TREATMENT AFTER A CLAIM IS MADE	Average number of days from claim lodgement to treatment approval date and/or first accessing treatment.	Agreed.
TIMELINESS OF RECOVERY PLANS	Percentage of recovery plans completed within 12 weeks of claim lodgement.	Agreed.
TIMELINESS OF PAYMENTS	Percentage of claims with an interval between date of receipt of invoice and medical benefit paid less than 20 days.	Agreed.

Sub-objective a.2: To encourage appropriate treatment and care to achieve optimum recovery of persons from injuries sustained in motor accidents.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY SUBMISISON
GP UTILISATION RATES	Percentage of claimants that saw a General Practitioner (GP) or specialist following their injury evidenced via a Certificate of Fitness required to submit a claim (except for funeral expense claims).	Agreed.
DECLINATURES POST 26 WEEKS	Percentage of claimants declined cover after being on benefits for 26 weeks.	This may not reflect a treatment decision but another threshold decision in the Scheme. A better KPI would focus on

		"Payments after 26 weeks in minor injury claims".
COMPLAINT VOLUMES	Percentage of complaints per Green Slip referred to SIRA's supervision teams.	Complaints made to date relate to many facets of the Scheme, not necessarily the timeliness of treatment. Many complaints are also dealt with in favour of an insurer. If a KPI is to be geared to complaints, then the KPI would be better worded "Treatment complaints upheld".
CUSTOMER SATISFACTION	CTP Assist Net Promoter Score (NPS) and customer effort scores.	Agreed.

With respective to sub-objectives a.1 and a.2 the Law Society submits generally that a critical KPI for encouraging early and appropriate treatment and care is the timeliness of the dispute system at the PIC which determines treatment disputes and the percentage of those requests for treatment disputed by the insurer.

Sub-objective a.3: To maximise claimants return to work or other activities.

KPI TITLE	**KPI DESCRIPTION**	**LAW SOCIETY SUBMISISON**
RTW MEASURES	Percentage of claims RTW at the following number of weeks after first receiving benefits (4, 13, 26, 52).	Agreed.
STAY AT WORK MEASURES	Percentage of claims stay at work at the following number of weeks after first receiving benefits (4, 13, 26, 52).	Agreed
RETURN TO EVERYDAY LIFE RATE FOR OTHER ACTIVITIES	Return to everyday activities including work around the house, social activities, and volunteering.	Query the extent to which this is measurable.

Objective (b)

Sub-objective b.1: To provide early financial support for persons injured in motor accidents.

KPI TITLE	**KPI DESCRIPTION**	**LAW SOCIETY SUBMISISON**
CLAIM ACCEPTANCE RATES	The rate of statutory benefits claims accepted by insurers. (Duplicated from KPIs in objective (a))	Agreed, although payment is a better indicator than acceptance.
TIMELINESS OF LIABILITY DECISIONS	Percentage of claims with less than a 28 day interval between the date the claim is reported and the date the liability decision is made. (Duplicated from KPIs in objective (a))	Agreed, but first payment is a better indicator of acceptance of liability.

TIMELINESS OF INCOME SUPPORT PAYMENTS	Percentage of claims with time between date of lodgement and first income support benefit less than 13 weeks.	Agreed.
INCOME BENEFIT TIMELINESS DISPUTES	Proportion of disputes related to timeliness of income benefit payments.	Level of disputes may not indicate timeliness of payments. Proportion of disputes found in favour of claimant is relevant to timeliness.
PAYMENT LEVELS	Verification of income support payments as a percentage of PAWE in line with the legislation.	This is not an indicator of financial support.

Sub-objective b.2: To provide ongoing financial support for persons injured in motor accidents.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
CLAIMS EXCEEDING 26 WEEKS DURATION	Percentage of claims that have not recovered from their injury and have been paid benefits beyond 26 weeks post the accident date. (To be supported by qualitative considerations).	This conflates minor/non-minor injury.
CLAIMS EXCEEDING 52 WEEKS DURATION	Percentage of claims that have not recovered from their injury and have been paid benefits beyond 52 weeks post the accident date. (To be supported by qualitative considerations).	Agreed.
TIMELINESS OF WEEKLY PAYMENTS	Percentage of claims that have received an income support benefit with return to work status code indicating not working for 30 days or more and weekly payments paid within the last 30 days.	No comment.
INCOME BENEFIT COMPLAINTS	Volume of complaints related to income benefit payments.	Volume of complaints alone is not a useful indicator. A better KPI would focus on “percentage of disputes found in claimants’ favour relating to income benefit payments”
INCOME BENEFIT AMOUNT DISPUTES	Proportion of disputes related to amount of income benefit payments.	As above, this needs to be geared to the outcome of a dispute.
INCOME BENEFIT TERMINATION DISPUTES	Proportion of disputes related to termination of income benefit payments.	As above, needs to be geared to the outcome of a dispute.

Objective (c)

Other stakeholders are better placed to comment in this regard.

The Law Society acknowledges that the CTP scheme continues to be mandatory for all NSW vehicle owners, hence object 's 1.3(2)(c) MAIA 2017' is satisfied and there is nothing further for the review to validate.

Objective (d)

Sub-objective d.1: To keep premiums for third-party policies affordable by ensuring that profits achieved by insurers do not exceed the amount that is sufficient to underwrite the relevant risk.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
PREMIUM AFFORDABILITY	Ratio of premium to the AWE.	The Law Society queries whether affordability should be measured against CPI, so a better KPI would focus on the annual percentage increase in premium by reference to CPI.
PREMIUM MAKEUP	Claims and expenses as a percentage of premium by insurer since 2017 Scheme inception.	This should read "Claims costs and expenses as a percentage of premium by insurer since 2017 Scheme inception."
PROFIT MARGINS AND MECHANISMS	Insurer profit margins on the average premium since 2017 Scheme inception and mechanisms to manage profit margins.	Agreed.

Sub-objective d.2: To keep premiums for third-party policies affordable by limiting benefits payable for minor injuries.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
MINOR INJURY CLAIM BENEFITS	Proportion of premium paid to claimants with minor injuries compared to non-minor injuries.	Agreed.
MINOR INJURY CLAIM DURATIONS	Percentage of claimants with minor injuries that finish treatment and care claims within 6 months.	Agreed.
MINOR INJURY CLAIM LEGAL COSTS	Percentage of legal costs to the total claims costs and dispute costs associated with minor injury claims.	Agreed.

In relation to sub-objective d.2, the Law Society submits that the time taken to resolve a minor injury dispute should be an additional KPI, together with the percentage of claimants with minor injuries who have not returned to sustained employment at 26 weeks and 52 weeks.

Objective (e)

Sub-objective e.1: To promote competition in the setting of premiums for third-party policies.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
CHANGES IN MARKET SHARE	Percentage change in market share year on year for each insurer.	Agreed.
MARKET PLAYERS	Retention of licensed insurers and addition of new entrants e.g. Youi	Agreed but also consider an opt in provision for government entities under Division 9.3.

Sub-objective e.2: To promote innovation in the setting of premiums for third-party policies.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
OPPORTUNITY FOR INNOVATION	Opportunities created for innovation. For example, changes in the point to point (P2P) space, and taxi and hire car industries.	This does not adequately address what the measures for innovation are.
RECOGNITION OF INNOVATION	Recognition of innovation. For example, via TEPL or Innovation Support.	This is not a performance indicator.

Sub-objective e.3: To provide the Authority with a role to ensure the sustainability and affordability of the compulsory third-party insurance scheme and fair market practices.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
SUSTAINABLE FOR POLICYHOLDERS	a) Ratio of the benefit paid to the premium paid. b) Average year on year increase in average premium. c) Ratio of premium to the AWE (Duplicated from KPI in objective (d)) d) High customer satisfaction based on Net Promotor Score (NPS) and Customer Experience Score (CES) results.	a) Agreed. b) Agreed. c) As above, should be measured against CPI, so KPI would be better described as annual percentage increase in premium by reference to CPI. (Duplicated from KPI in objective (d)). d) Agreed.
SUSTAINABLE FOR INSURERS	Insurer profit margins on the average premium since 2017 Scheme inception. (Duplicated from KPIs in objective (d))	Agreed.

SUSTAINABLE FOR GOVERNMENT	a) A well and fair functioning insurance market is in place to cover motor vehicle accident injuries (As outlined in the other KPIs for objectives (e) and (f)) b) Early and appropriate treatment and care (As outlined in the KPIs from KPIs in objective (a) and (b)) c) Minimal number of disputes, and where there are disputes that they are justly resolved (As outlined in the KPIs from KPIs in objective (g))	Agreed.

Objective (f)

To deter fraud in connection with compulsory third-party insurance.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
FRAUD INVESTIGATIONS	Volume of investigations as a percentage of total claim volumes.	Agreed.
FRAUD PROSECUTIONS	Volume of prosecutions annually and compared to volume of open claims.	Prosecutions are not an accurate indicator of fraud in a current year and difficult to prosecute. A better measure is the number of withdrawn claims, discontinued court proceedings or claims where fraud is alleged and found in favour of insurer.
FRAUD RECOVERY RATES	Fraud recovery rates annually expressed as amount recovered in proportion to premiums.	The Law Society queries how this can be measured if it is referring to amounts paid out on fraudulent claims, or is it referring to money retrieved?
COMPARISON AGAINST HOSPITAL DATA	Ratio of CTP claims that eventuate compared to the number of road accident victims that attend hospital.	Agreed. Another point of comparison against hospital data should be the increase in claim frequency per accident. Comparison of hospital data against other data such as geographical location of motor accidents should also be considered
PREVENTATIVE MEASURES	Programs in place to prevent fraud from occurring.	Agreed.

Objective (g)

Sub-objective g.1: To encourage the early resolution of motor accident claims.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
AVERAGE CLAIM DURATIONS	Average claim durations (days) from lodgement to closure, separately considering statutory and common law claims.	Agreed.
TIMELINESS INTERNAL REVIEW DECISIONS	Percentage of claims with time between date of complaint and date of resolution for internal disputes less than 28 days.	Agreed but see comment at sub-objective g.2 below. Also, the term 'initial decision by insurer' is preferred to 'complaint'.

Sub-objective g.2: To encourage the quick resolution of disputes.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
TIMELINESS INTERNAL REVIEW DECISIONS	Percentage of claims with time between date of complaint and date of resolution for internal disputes less than 28 days.	Agreed but this is limited to statutory benefit disputes and other measures are necessary to determine resolution rate. The Law Society also notes that the duration of disputes at the PIC has relevance here as well as to sub-objective g.1.

Sub-objective g.3: To encourage the cost-effective resolution of disputes.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
COST OF INTERNAL REVIEWS	Average settlement cost per internal review as a proportion of average claim cost for claims that are settled via internal review and do not progress to DRS (now PIC).	One issue arising is the scope to resolve a statutory benefit dispute. Insurers are of the view that they are unable to compromise on these disputes at any time. In addition, cost effective resolution of these disputes is not reflected in the regulated fee, nor in matters that do not progress beyond internal review.
COST OF SETTLEMENTS	Costs of settlement for claims with disputes compared to claims without disputes.	This is not a measure of cost effectiveness given regulated fees apply regardless of the stage of resolution and little overall saving in stage 4 costs.
COST OF ESCALATION	Average settlement cost per review as a proportion of average claim cost for claims that escalate to DRS (now PIC) review, considering legal representation.	The Law Society is unclear what this description intends.

Sub-objective g.4: To encourage the just resolution of disputes.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
INTERNAL REVIEW OUTCOMES	Percentage of insurer internal reviews determined in favour of claimant.	Agreed.
OVERTURNED DISPUTES	Percentage of disputes heard by SIRA's Dispute Resolution Services (DRS) that are overturned.	Agreed.
OVERTURNED LITIGATIONS	Percentage of litigated claims overturned.	The Law Society is unclear if this is referring to disputes or claims and this should be amended to reflect the intention of the KPI.
COMPLAINTS ABOUT DISPUTES	Percentage of finalised disputes that subsequently make a complaint.	Complaint may be irrelevant to a just outcome. A just outcome may not satisfy both parties.

The Law Society also believes that a KPI should be devised to compare the original allegation of contributory negligence made by an insurer in a liability dispute with the ultimate finding of contributory negligence.

Objective (h)

To ensure the collection and use of data to facilitate the effective management of the compulsory third-party insurance scheme.

KPI TITLE	KPI DESCRIPTION	LAW SOCIETY COMMENT
OPEN DATA TOOL	Usage rates of the online Open Data analysis tool.	Agreed.
DATA QUALITY	Error rates in the data submitted to the UCD by individual insurers.	This should also include timeliness of data reporting.