The Law Society
OF NEW SOUTH WALES

Our ref: ICC:RMmm180826

18 August 2026

DCS Statutory Review team
Policy, Strategy and Governance
McKell Building, Rawson Street
SYDNEY NSW 2000

Via email: motoraccidentinjuriesreview@customerservice.nsw.gov.au

Dear Statutory Review Team,

STATUTORY REVIEW OF THE MOTOR ACCIDENT INJURIES ACT 2017 (NSW)

The Law Society is pleased to contribute to the Statutory Review of the *Motor Accident Injuries Act 2017* (NSW).

We have reviewed the Compulsory Third Party Insurance Issues Paper and provide the Law Society's responses to the specific questions therein by way of the **enclosed** Comments Table. The Law Society's Injury Compensation Committee contributed to this submission.

Please direct any questions regarding this submission at first instance to Monika Matesa, Head of Commercial and Advisory Law Reform, on (02) 9926 0109 or monika.matesa@lawsociety.com.au.

Yours sincerely,

Ronan MacSweeney
President

Attachment

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Compulsory Third Party Insurance – Issues Paper 2026

Law Society of NSW Feedback

No.	Question	Law Society comments
What the Act aims to achieve		
1.	Do the objectives of the Act remain valid? Why or why not?	In general, the Law Society considers the objectives of the *Motor Accident Injuries Act 2017* (NSW) (**the MAIA**) remain valid, but notes several barriers observed by members to the scheme's achievement of those objectives. The MAIA's first object, that of encouraging early and appropriate treatment and care, is undermined by delays in determining treatment disputes, especially where causation is disputed. We outline our concerns regarding the affordability of premiums at [3] below. Overseeing insurers for the purpose of ensuring that they provide sufficient information to consumers in relation to the calculation of premiums and consumers' options to negotiate premiums and seek discounts would encourage competition and realistic pricing. We consider the impacts of current scheme practices on the availability of early and ongoing financial support for persons injured in motor accidents at [12]-[14] below. We have also addressed below our members' experience in relation to the resolution of disputes. The Law Society also strongly encourages the review to consider our members' feedback concerning the operation of clause 25 of the *Motor Accident Injuries Regulation 2017* (NSW) (**the MAIR**) in relation to legal fees for insurers' legal representatives, insofar as an object of the MAIA is to deter fraud in connection with CTP insurance. The case studies at [31] illustrate the value of insurers' lawyers in conducting investigations in claims where there is a risk of fraud or lack of merit, which yields substantive savings to the scheme, but as a result of the diminished sums payable to claimants in those matters, insurers' lawyers are required to write off or repay significant sums of legal costs that would otherwise be payable to them for those services.
2.	What are the top 3 most important things that you think may need to change in the Act (if anything) to support it to achieve and/or balance its objectives? Please explain.	The Law Society has taken a holistic approach to the questions posed in the consultation paper and considers that such an approach is necessary when considering improvements to the operation and sustainability of the Scheme. The following key issues are further discussed in the balance of this table, but ought not to be taken to represent a particular position that they take precedence over other matters considered in this submission. The Law Society considers that the provision of legal assistance, supported by appropriate reviews to the costs regime in the MAIA and the MAIR, at earlier stages of the claim process

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		would assist in (1) achieving fairer and more cost-effective outcomes by reducing instances of unmeritorious claims (by providing early advice on claimants' entitlements and the limits of those entitlements); and (2) promoting efficient conduct of claim processes generally, having regard to practitioners being better placed to understand the operation of the Scheme and the rights and obligations of claimants and insurers. We have referred below to our prior submissions over recent years regarding the lost opportunities to the scheme created by lack of appropriate reviews to the costs regime. The Law Society urges that attention be given to expanding the availability of appropriately qualified medical specialists able to perform medical assessments, the lack of which is resulting in significant delays and in some cases halting of claims where appropriate specialists are unavailable or unwilling to perform assessments. We also consider that it is necessary to review the powers and processes of insurers in conducting pre-accident weekly earning (**PAWE**) calculations, in order to reduce the significant exposure to the Scheme of overpayment risks that are not able to be addressed until a claim is in its advanced stages, when there may or may not be an award of damages sufficient to offset any earlier overpayments. The Law Society has previously drawn attention to the increasing prevalence and complexity of PAWE disputes[1] and the somewhat anomalous fact that there is no scope for lawyers to assist the Scheme by acting in such disputes because there is no allowance for costs to do so and no allowance for claimants to obtain responsive evidence to insurers' investigative and forensic accountant reports.
Scheme sustainability		
3.	What other issues (if any) should the statutory review consider relating to premium affordability and financial sustainability? Please explain. Note other relevant issues such as eligibility criteria are discussed in other parts of this paper	Members observe that levies imposed as part of premiums for the CTPCare and Lifetime Care and Support programmes are contributing to the overall increasing costs of premiums and green slips. Those levies have, over the life of the Scheme, increased disproportionately to CPI; in one case, the Lifetime Care and Support levy component of a premium almost doubled in one year. In our members' experience, total levies appear to represent more than 20% of the total cost of premiums. They suggest greater oversight and transparency of these levies is warranted, including in relation to their increases year-on-year, the proportion of premiums they

[1] See, e.g., Letter to State Insurance Regulatory Authority dated 30 July 2021, pp 8-9.

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		represent, and the assumptions underlying the calculation of the Medical Care and Injury Services (**MCIS**) levy. Members have expressed concern that the Scheme is at risk of exposure to significant liability for statutory benefits, including wage payments, in circumstances where insurers do not have effective powers to require production of evidence or documents to verify a claimant's pre-injury earnings (e.g., tax returns). Under the 1999 Act, employer declarations in relation to earnings were part of the claim form; the present iteration of the Scheme relies more heavily on claimant declarations and insurers, under time pressure to make determinations, often rely on claimants' representations that they are, in fact, earners entitled to wage payments for the purpose of making interim payments. Overstatement of wages can subsequently be detected when a common law claim is brought and tax returns are produced, by which stage overpayments have already occurred and if the claimant is not entitled to damages for non-economic loss, there may be no award (or an award of insufficient sum) to allow for the offset of those overpayments. The result is a net cost to the Scheme that might have been avoided.
4.	When should the transitional excess profit and loss mechanism in Schedule 4 of the Act end? Please explain	The Law Society supports the retention, at this stage, of the transitional excess profit and loss mechanism, as a means of reducing insurer 'super profits'. There is no clear policy or practical rationale for removal of the 'clawback' for which it provides, and no reason that it could not be retained and simply not used if unnecessary; alternatively, it could be applied such that it requires insurers to demonstrate genuine innovation in order to avoid clawbacks.
5.	What should replace the transitional excess profit and loss mechanism in Schedule 4 of the Act? Please explain.	No further comment.
6.	Do you think the current assessment of claims handling expenses as part of Schedule 1E of the Guidelines is sufficient? Why or why not?	No further comment.
Eligibility criteria and scheme coverage		
7.	What other issues (if any) should the statutory review consider about eligibility criteria or scheme coverage? Please explain.	No further comment.

Department of Customer Service

Compulsory Third Party Insurance – Issues Paper 2026

Law Society of NSW Feedback

No.	Question	Law Society comments
Threshold injury and other definitions		
8.	Do you support adjustment disorder being a 'threshold injury'? Why or why not?	No. The Law Society maintains its position as set out in its submissions to the Standing Committee on Law & Justice[2] for the 2025 Review of the Compulsory Third Party Insurance Scheme that removal of adjustment disorders from the definition of "threshold injury" is appropriate and reflects experience that claimants may suffer from chronic adjustment disorders and the associated symptoms years after the index injury. Further, psychiatric injuries may have delayed onset or require a substantial period of time for diagnosis.
9.	Do you support changing the definition of 'injury' in the Act? Please explain. a. If yes, how would you change the definition of injury? Please explain.	Yes. The Law Society supports the removal of subparagraph (c) of the definition ("damage to artificial members, eyes or teeth, crutches or other aids or spectacle glasses"). Since they are not included in the definition of a "threshold injury," they fall within the definition of "injury" and theoretically give the claimant access to common law damages. We suggest that it was never the intent of the Act to have that result and yet deny a person with a physical injury that might prevent them from returning to work, but which is a threshold injury, that access. The Law Society has previously[3] advocated extensively for the adoption of a 'narrative' form of definition that relies on objective evidence of physical and/or psychological injury, but is not solely dependent on a numerical figure (e.g., a WPI percentage). Rather, the definition could comprise a test that accounts for the consequences of the injury on the person, such as: A permanent reduction in physical, psychosensory or intellectual potential that is theresult 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.

[2] Letter from the Law Society to the Hon. Greg Donnelly, MLC (Standing Committee on Law and Justice), p 2.
[3] Letter from the Law Society to State Insurance Regulatory Authority dated 30 July 2021, p 10.

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		As previously noted,[4] the Law Society supports further clarification of the definition of not only "injury" but its other interdependent definitions; for example, the decision of the Court of Appeal in *Allianz Australia Insurance Limited v Estate of the Late Summer Abawi* [2025] NSWCA 85 was that an injury to skin that was not also a nerve injury was a "soft tissue injury" and therefore a "threshold injury," which might have the result that some cases of injury such as road rash and burns would be 'caught' as threshold injures despite their potential for lasting impact on an injured person. Additionally, we suggest that the review consider the recent decision of *Mandoukos v Allianz Australia Insurance Ltd* [2026] NSWSC 911 for the purpose of clarifying the abovementioned definitions. Firstly, we note that the Court reinforced that an injury to bone does not fall within the statutory definition of a "soft tissue injury," and further, that what is required in assessing whether or not an "injury" has occurred in the relevant sense is whether there has been a physical change or disturbance to the claimant's body. In that case, the claimant underwent surgery that was reasonable and necessary as a result of a motor accident, but which caused a further injury by way of removal of bone tissue. That constituted an injury consequential to the original motor accident because it had caused a physiological change that did not exist before the accident and was necessitated by the accident, and it was irrelevant that the injury was caused by a procedure that was intentionally and consensually undertaken by the claimant for therapeutic purposes.
10.	What else should be included or excluded from the definition of treatment and care? Please explain.	No further comment.
Scheme coverage		
11.	Would you support expanding or further restricting the scheme's coverage in certain circumstances? Why or why not? a. If yes, please expand on what these circumstances should be and explain why	The Law Society supports retaining the existing test for the liability of the Scheme for treatment and care, insofar as it requires that the treatment be "reasonable and necessary" in the circumstances. It provides a two-part safeguard to control the liability of the Scheme while being sufficiently flexible to account for cases where the treatment or care in question is of a less usual kind, such as in relation to assistance with pet care.

[4] Above n 1, p 4.

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		The Law Society also supports[5] extending the availability of common law damages to all injured persons with a degree of permanent impairment greater than 10% (regardless of whether their injuries are classified as "threshold injuries"). An injured person may have suffered a serious soft tissue injury that yields permanent impairment of greater than 10% or suffer multiple injuries that are all threshold injuries and as a result of these injuries, suffer from permanent impairment greater than 10%, but not be entitled to common law damages because of the anatomical nature of their injuries. Seriously injured persons ought to be entitled to damages that reflect the debilitating effect of their injuries. Following the decision in *Job v Jones; State of NSW (Fire and Rescue NSW) v Jones*[6], we suggest that s 1.9(2) of the MAIA (the equivalent of the provision under consideration in that case) be clarified in accordance with the decision reached by the Court having considered a line of appellate authority to the point that s 1.9(2) is intended to 'carve out' from the MAIA injuries that arise gradually over a series of incidents in connection with the nature and conditions of a person's employment.
Claims process		
12.	What other issues (if any) should the review consider about the claims process? Please explain.	Members have reported that insurers are making decisions, including in relation to statutory benefits and whether injuries are threshold injuries, with very little information or investigation. That information-gathering and investigation then takes place when an internal review is sought and conducted, at which point the insurers in question are (apparently for the first time) taking steps to obtain clinical notes and medical reports. This is inconsistent with the purpose of an internal review, which is to clarify and assess the original decision, not to investigate a claim from scratch. The process causes time delays – particularly if insurers leverage the additional time they are permitted to conduct an internal review by requesting further information,[7] which could have been sought at an earlier stage – and leads to more matters proceeding to the Personal Injury Commission (**the Commission**) to seek review. Members have also noted that insurers tend to rely on factual investigators and/or forensic accountants in the early stages of claim investigation, rather than seeking relevant documents or evidence from claimants, particularly in the case of self-employed claimants,

[5] Above n 1, p 3.
[6] [2026] NSWDC 221 (1 July 2026)
[7] State Insurance Regulatory Authority, Motor Accident Guidelines, cl 7.25, table 7.1.

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		whose earnings (for the purpose of wage payments) are less readily ascertainable, and high net worth individuals. These practices also serve to drive up Scheme costs. Consideration should be given to discouraging a default practice of insurers outsourcing financial assessments and only permitting them in circumstances where the facts of the matter justify the additional cost and delay of obtaining expert opinion. To illustrate, members have reported receiving referrals from the CTP Legal Advisory Service for unrepresented claimants which are largely PAWE disputes, where the claimant is in dispute with an insurer regarding PAWE calculations. In members' experience, the insurers in such disputes almost invariably rely on the report of a forensic accountant; this leads to a situation where claimants are intimidated and feel unable to challenge the insurer without obtaining their own forensic accountant but have no right to legal representation in a PAWE dispute before a merit reviewer and no right to claim the cost of a forensic accountant's report in response. This has the potential for unjust assessment processes and outcomes should a claimant lack the knowledge and resources of their own to conduct the dispute opposite a well-resourced insurer. Consideration should be given to allowing a regulated legal fee for merit review disputes and allowing a fee for a forensic accountant's report in reply, in order to ensure claimants are not unreasonably deprived of access to justice by way of proper advice on their rights in PAWE disputes. This would also give lawyers the opportunity to assist the Scheme by acting as a 'filter' for unmeritorious claims and otherwise progress them more efficiently, thereby lessening the costs and demands on the Scheme. We also note that there is no scope for insurers to engage solicitors to deal with PAWE disputes, which represents a significant lost opportunity to deal effectively with a PAWE dispute at an early stage; reduce the risk of overpayments; and reduce the demand on claims officers to carry out PAWE assessments.
Pre-accident average weekly earnings calculation		
13.	Does the process to calculate weekly average pre-accident earnings for statutory benefit income support need improving including for self-employed injured people? Please explain.	As noted in our response to [3], insurers do not have an effective power to compel claimants to produce further evidence, such as tax returns and bank statements (or to compel employers to provide materials) in order to make a realistic assessment of weekly average pre-accident earnings for the purpose of calculating statutory benefit income support. This results in the risk of overstating the relevant wage figure for statutory benefits and therefore overpayment, until such time as the overstatement is detected, such as

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		during the assessment of damages when the injured person has brought a claim for common law damages. A related issue is that members have experienced difficulties faced by self-employed persons because their current statutory entitlements, that is, the proceeds or income they receive from the proceeds of the business (which is calculated as the gross business income less expenses).[8] That formulation does not allow self-employed persons operating a business to meet continuing expenses associated with the business' continuing function, such as rent. This may lead to a situation where an injured self-employed person's business ceases operation during the period of incapacity due to the inability to meet fixed business expenses. We suggest that a compromise approach to addressing this issue might involve forgoing the deduction of certain fixed expenses, such as rent, from the calculation of a self-employed person's business earnings for a defined period, say 6 or 12 months post-incident.
14.	Do you support the Guidelines setting a timeframe for when an insurer must calculate pre-accident average weekly earnings? Why or why not?	Yes. Members report claimants experiencing long delays in PAWE assessments and therefore long periods with no income support. We suggest a timeframe of say 14 days from the point at which the insurer receives sufficient information from the claimant to determine liability, at which point interim payments should commence pursuant to s 3.6(5) of the MAIA.
Treating medical practitioners		
15.	Do you think treating medical practitioners have an adequate role in the CTP insurance scheme? Please explain.	Members continue to report issues regarding the interpretation by insurers of the requirement imposed on insurers by clause 4.155 of the Motor Accident Guidelines to, "Before arranging a medical examination… inquire with the injured person's treating medical, rehabilitation and health service practitioners promptly to try to resolve the issue." The nature and extent of this obligation remain unclear. Members have reported insurers paying for reports from those service providers, a step taken solely for the purpose of compliance with clause 4.155. This slows down the claims process, and does not necessarily assist in the management of the claim. Further, enforcing this requirement before insurers are permitted even to arrange medical examinations causes flow-on delay due to lack of availability with medical experts. Where "the issue" relates to the question of whether or not certain medical treatment is reasonable and necessary, the compliance burden and delay associated with insurers'

[8] MAIA, sch 1, cll 3-4. See also *Zou v QBE Insurance (Australia) Limited* [2024] NSWPICMR 4 at [80].

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		compliance with clause 4.155 of the Motor Accident Guidelines might be eased by allowing insurers to proceed on the basis of a presumption that medical treatment prescribed by a treating medical professional is reasonable and necessary. That could be justifiable on the basis that the treater has direct knowledge of, and experience in, the claimant's condition that has been established over a period of time and multiple consultations with the claimant. Medical examinations dealing with whether treatment is reasonable and necessary could therefore only be required if there are factual circumstances that justify dispensing with that presumption. Otherwise, the Law Society defers to the Australian Medical Association regarding the role of treating medical practitioners within the Scheme.
Joint medico-legal assessments		
16.	Do you support the use of joint medico-legal assessments? Why or why not?	The Law Society generally supports the use of joint medico-legal assessments as a means by which parties can reduce costs; accelerate claim processing; and avoid exposing claimants to multiple examinations, where parties are able to agree on the appropriate medical expert and form of instructions. The Law Society does not support mandating the use of single joint medico-legal assessments. This is likely to unnecessarily increase the rigidity of the medical dispute process and increase the likelihood of parties proceeding to judicial review. More moderate approaches might include the publication of more information to encourage parties to adopt a collaborative approach to medico-legal assessments or preventing parties who agree to a joint medico-legal assessment from tendering a further equivalent report (e.g., another primary report where the jointly obtained report was also a primary report) from another assessor of the same speciality. SIRA might be appropriately placed to serve as the 'referee' on approach by parties seeking to agree on one of a selection of potential candidates.
17.	Are there barriers to using joint medico-legal assessments and if so, what are they? Please explain	See our response to above [16]. Further, we suggest that greater oversight of insurers is warranted in relation to the tendency of insurers, in some of our members' experience, to nominate joint medico-legal assessors from a limited panel of those specialists frequently qualified by the insurer. A more diverse approach to joint medico-legal proposals could assist in encouraging parties to be open to joint medico-legal assessments.

Department of Customer Service

Compulsory Third Party Insurance – Issues Paper 2026

Law Society of NSW Feedback

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Authorised health practitioners		
18.	What has been your experience accessing and engaging authorised health practitioners under the CTP scheme?	Members report that the list maintained by SIRA of Authorised Health Practitioners (**AHP list**) is not yet digitised and difficult to navigate. They also report a paucity of doctors and specialists in particular areas, such as rehabilitation physicians; neurosurgeons; female gynaecologists; and child psychiatrists. In situations where an appropriate specialist cannot be engaged by the AHP list, the relevant claims cannot proceed at all absent agreement between the parties. Further, members report encountering practitioners on the AHP list who either do not perform the required assessments; only agree to accept appointments when engaged by a particular party (e.g., an insurer); or only perform a very limited number per annum.
19.	Do you support adjusting the fees that authorised health practitioners can be paid under the CTP scheme? Why or why not?	Members suggest that the limited fees available to AHPs deters practitioners from participating in the AHP list. Further, we suggest that capping the fees (or at least the current caps on fees) does not in fact promote the sustainability of the Scheme. For example, the limited fees cause some AHPs refuse to consider evidentiary materials above a certain page limit. This then requires those instructing AHPs to perform additional work in reduce briefing materials to comply with those confined page limits, particularly in complex cases, which is a significant challenge, particularly where the AHP is jointly engaged and briefing materials must be agreed between the parties. The effect is that the unfunded burden on AHPs is simply shifted to a part of the Scheme that is also not resourced to perform that work, but with the additional risk that those tasked with limiting the instructions provided to AHPs may lack the medical expertise to confine briefing materials in such a way that does not compromise the completeness of the medical information provided to the AHP. That may then lead to a need for reassessments or supplementary assessments, or inaccurate conclusions on which decisions about statutory benefits and damages awards are to be founded. Therefore, the Law Society supports a review of the fees that AHPs can be paid under the Scheme in order to ensure that they are capable of attracting AHPs that have the speciality and capacity to meet the demands of the Scheme. Further or alternatively, fee structures can be developed to create flexibility in charging for more complex matters, such as a standard fee complemented by additional fees should materials briefed exceed a certain page limit.

Psychological and psychiatric injuries		
20.	Does the CTP scheme support psychological and psychiatric injuries as well as it does physical injuries? Why or why not?	No, in the sense that some recognised psychiatric illnesses are subject to constraints on benefits and damages because they are regarded as "threshold injuries." See also our response to [8]: those with chronic adjustment disorders in particular, or those with such disorders that have delayed onset or take some time to diagnose, may suffer from debilitating symptoms for an extended period yet not be entitled to benefits for treatment beyond 12 months following a motor accident.[9]
People who lose a loved one		
21.	When people lose loved ones in motor crashes, should the claims process be adapted to reflect their circumstances? Please explain. a. If yes, how else could the claims process better support this group of people while continuing to meet the objectives of the Act? Please explain.	Members report that the claims process where people have lost loved ones generally works well. We also note the adoption of the term "motor crash" rather than "motor accident" in communications with those involved in claims concerning a death,[10] though members have reported no particular preference amongst those they encounter in practice who are affected by claims involving a death. Though the Law Society certainly supports a trauma-informed approach to claims management, which includes taking into account the views of all stakeholder groups representing affected parties, it also supports the retention of the term "motor accident" for the purpose of the regulatory and legislative frameworks of the CTP scheme.
Dispute resolution		
22.	What has your experience been with the dispute resolution process? Please provide details.	Members report significant delays in appeals, particularly medical reviews, in addition to delays in obtaining primary medical assessments. This is driven by the paucity of appropriately qualified specialists available to convene a medical panel. Members have reported waits of more than a year for some specialities, such as respiratory physicians, which are ongoing given the insufficient number of those specialists available. Other examples are psychiatrists, urologists, child psychiatrists and prosthodontists; as to the latter, one practitioner has reported two cases where insurers' medical assessments indicated a prosthodontist's opinion is required, but there is no such specialist in the

[9] MAIR, s 3.28(1)(b).
[10] State Insurance Regulatory Authority Motor Accident Guidelines, General Introduction to the Motor Accident Guidelines.

		Scheme and those matters are therefore unable to progress. These issues drive delays in assessments and reviews. The Law Society also understands that members consider the current pathway in the Commission for resolving treatment disputes to be unsatisfactory due to the delays in determination of those disputes, which includes both complex disputes and relatively low-cost and simple disputes. Measures such as triaging or threshold categorisation in combination with more efficient means of dealing with simple disputes – such as 'on the papers' determinations in appropriate cases, or redirection to an alternative pathway (subject to appropriate protections to ensure the availability of legal representation and appeal mechanisms) – could assist in dealing with those delays. Another means of accelerating the process of dealing with treatment and care disputes may be to permit claimants to bypass making a request to an insurer for an internal review before proceeding to the Commission. This measure may also serve to encourage insurers to refine their internal review processes (see our response at [12]) in order to divert claimants away from choosing to proceed to the Commission.
23.	What other issues (if any) should the review consider about the dispute resolution pathways under the Act? Please explain.	No further comment.
Causation of injury		
24.	Do you support disputes about causation of injury being decided by Courts or Commission members instead of a medical assessor? Why or why not?	The Law Society agrees that it is appropriate for disputes regarding causation to be determined by Courts, or Commission Members, insofar as those disputes relate to legal or normative causation as opposed to medical causation; that is, questions of whether or not a person's injuries for which benefits or compensation are sought resulted from motor accident in NSW, as opposed to questions of whether the motor accident in question is capable of causing the injuries in question. Requiring medical assessors to apply a legal test in addition to considering medical issues increases the likelihood of challenge to assessment certificates because consideration of legal issues is beyond the scope of their expertise. The Law Society supports assessment certificates remaining binding on the parties only insofar as they relate to the assessment of whole person impairment and the question of whether it is or exceeds 10%.

Medical review panel		
25.	Do you support changing the Medical Review Panels' remit under the Act so they: a. are not to conduct a new medical assessment? b. must meet more set criteria before they can review a medical assessment decision? Please explain your response.	The Law Society does not support changing the legislative remit of Medical Review Panels[11] so as to wholly restrain them from conducting new medical assessments. Instead, the Law Society would support allowing the Medical Review Panel discretion as to the extent of any new assessment that is to be conducted; for example, in a case where multiple injuries are under consideration and the parties agree that they are only in dispute as to one, the Medical Review Panel ought to have the discretion to proceed on that basis. This approach would reduce the time and costs associated with a fresh medical assessment where it might be unnecessary to conduct one and instead allow for a more targeted and efficient approach to review of disputed assessment certificates. The Law Society does not consider it necessary to impose more restrictions on Medical Review Panels before they proceed to review a medical assessment decision.
26.	What could be the grounds on which a medical assessment decision should be reviewable? Please explain.	No changes suggested.
Legal fees and access to legal support		
27.	What other issues (if any) should the review consider about legal fees that can be charged or people with injuries' access to legal support? Please explain.	The Law Society repeats its previous submissions, particularly its 2025 submissions to the Standing Committee on Law and Justice, and reiterates its concern that the current level of regulated costs does not reflect the actual costs of providing legal advice in motor accident matters.[12] As stated in our 2025 submissions, inadequate and non-existent allowances for legal costs impact access to justice by discouraging claimants with otherwise meritorious claims from pursuing internal review or other pathways. Further, and as noted above, claimants are currently at a disadvantage in PAWE disputes given the current practices of insurers to retain forensic accountants to address the relevant calculations and the lack of any allowance for regulated fees for representation in PAWE disputes. The value of supporting legal representation for Scheme participants ought also to be seen in the efficiencies lawyers create for the scheme, which furthers its sustainable operation. Properly advised and represented, claimants are better placed to understand

[11] MAIA, s 7.26.
[12] Above n 1, p 7.

		both their entitlements and the limits of those entitlements. That understanding controls the commencement of unmeritorious claims and assists in the efficient progression of other matters. The clearest example is a dispute about the amount of a claimant's PAWE, the subject of [13] and [14] above. A PAWE dispute is resolved by merit review.[13] However, legal costs for a merit review are only payable where the dispute is about a "regulated merit review matter", and the list of such regulated matters[14] includes only disputes about whether an insurer may refuse to pay statutory benefits; that is, merit reviews dealing with disputes about how much a claimant is entitled to be paid do not attract any allowance for legal costs. A practitioner is not entitled to be paid for legal services in connection with a claim for statutory benefits unless the regulations or the Commission permit it[15], and costs agreements are excluded for statutory benefits matters[16]. Costs are only available at the review panel stage,[17] that is, after the completion of the merit review process (without funding) and subject to the President's approval of an application for referral to the review panel. The result is that the claimants of the kind described at [12] and [13] above, often self-employed people facing an insurer's forensic accounting evidence, cannot obtain legal representation for a PAWE dispute on any basis. Improving the PAWE calculation process, as proposed at [13] and [14], will assist, but claimants also need representation when the calculation is disputed, and at present the costs framework makes that impossible. The Law Society therefore recommends that clause 1(2) of schedule 1 to the MAIR be amended to include disputes about the amount of statutory benefits payable under Division 3.3 of the MAIA, with provision for the reasonable cost of a responsive forensic accounting report where the insurer relies on forensic accounting evidence. The Law Society also considers that the caps applicable to costs recoverable in "exempt minor claims"[18] require review. Costs in an exempt minor claim are capped at $5,000, and uplifts to $10,000 and $15,000 are unavailable where an "associate", meaning another

[13] MAIA, sch 2, cl 1.
[14] MAIR, sch 1, cl 1(2).
[15] MAIA, s 8.3(4).
[16] MAIR, cl 25(5).
[17] MAIR, sch 1, cl 1(3).
[18] MAIR, cl 26.

		occupant of the same vehicle represented by the same firm, has also made a claim. Two children injured in one crash are each capped at $5,000, for claims that could potentially be conducted over years; require a future economic loss assessment built from school records; have specialised requirements for medical evidence; and require the approval of the District Court of NSW. Because the figures are flat dollar amounts rather than monetary units they are not indexed, and have remained unchanged since 1 November 2016 and therefore are even further from reflecting the actual costs of providing legal services in those matters.
28.	Where relevant, what has been your experience with legal representatives under the CTP insurance scheme? Please explain.	No further comment.
29.	What role should legal representatives play in supporting people with injuries in the CTP insurance scheme? Please explain.	The consultation paper suggests[19] that the feedback of some stakeholders is that "increasing lawyers' involvement in the process could make it more adversarial, increase costs and delay how quickly disputes are resolved." As already noted, legal representatives serve the Scheme's objectives in several ways and most effectively when involved early: advising injured people on their entitlements and their limits at the outset of a claim; ensuring the evidentiary record before the insurer is complete before decisions are made; identifying and challenging incorrect decisions at internal review within the strict 28 day period; and resolving disputes without a hearing, which is how most represented statutory benefits disputes conclude. Representation is the principal means by which incorrect decisions are corrected, and properly advised claimants are less likely to pursue unmeritorious disputes, which serves the efficient operation of the Scheme as a whole. Lawyers' professional obligations prevent them from advocating for outcomes beyond their clients' legitimate rights and entitlements and require them to use legal processes responsibly. Given the context of the highly regulated and limited costs regime within the Scheme, lawyers' involvement of itself is unlikely to make the Scheme's processes "more adversarial". It would not be in either lawyers' or claimants' interests for them to adopt an adversarial approach, and the suggestion appears to proceed from the assumption that insurers' decisions are usually correct and ought not be challenged. The Scheme's data does not bear out the proposition that restricting lawyers' involvement in the Scheme would prevent it from becoming "more adversarial": of the 8,352 internal reviews applied

[19] Compulsory Third Party Insurance Issues Paper, July 2026, p 32.

		for in 2025, insurers' initial decisions were overturned in the claimant's favour in 20.65% of cases, on the back of a downward trend since 2023.[20] The Law Society is unable to agree that CTP Assist is an adequate substitute for legal representation, as CTP Assist is unable to provide legal advice to claimants.[21] Similarly, the handling of a complaint is in part dependent on its proper articulation and support, which would be improved when informed by legal advice on the operation of the scheme and the relevant claimant's entitlements. Given this, the efficiency of the Independent Review Office's complaints handling process (and complaints handling processes more generally) would be improved with the support of timely legal advice.
30.	Apart from legal representation, what else could be used to assist people who are injured in motor crashes to understand and go through the claims and dispute resolution process? Please explain.	Information services can help people navigate the claims process, but the gaps members observe are practical rather than informational, and information is not a substitute for advice once a decision has been made. Liability notices, for example, already inform claimants of their review rights and of where they can obtain assistance. The difficulty members have observed is that claimants sometimes do not receive the notice at all, yet the 28-day period to seek internal review runs regardless. The Law Society suggests that insurers be required to take reasonable steps to confirm that a claimant has actually received an adverse decision notice, and that the review period not run, or that it be readily extendable, where the claimant did not receive it or cannot be confirmed to have received it. CTP Assist performs a useful navigation function and the Law Society supports it. However, further to [29] above, it should not be positioned as a substitute for legal advice once an adverse decision has been made. Whether to seek internal review, on what grounds, with what supporting material, and whether to proceed to the Commission are questions requiring tailored legal advice on the merits of the particular claim, which an information service cannot and should not provide. That gap is compounded by the matters raised at [27]: no costs are payable for legal services in connection with an internal review,[22] which is the stage at which, arguably, advice is most critical. The Law Society also supports publication of dispute outcome data, so that injured people and their advisers can understand how comparable disputes have been resolved.

[20] State Insurance Regulatory Authority, 2017 CTP Scheme Open Data, p 12, accessed 14 August 2026.
[21] See also Letter to Mr Chris Rath (Standing Committee on Law and Justice) dated 7 November 2022, p 2.
[22] MAIR, cl 23.

31.	Do you support clause 25 of the Regulation not applying to fee arrangements between insurers and their legal representatives? Why or why not?	Further, we encourage the review to consider the Law Society's previous submissions[23] to the effect that it is appropriate to review the current threshold ($75,000 in damages) for 'contracting out' of the regulated costs regime, for both claimant and insurer solicitors. The threshold can prevent access to justice for entire cohorts of claimants, including: (1) those with non-threshold injuries; (2) whole person impairment of 10% or less with little or no economic loss; (3) retirees; (4) those in receipt of the disability support pension; (5) carers; and (6) persons in unpaid work, because solicitors' fees are so heavily curtailed and their ability to provide legal services therefore constrained, unless the likely value of a claim will exceed the threshold. Insurers' legal representatives are typically allocated files as members of a panel, and do not have the discretion to refuse instructions for matters likely to be of limited value. Claimant solicitors are able to (and more likely) to refuse instructions where damages are likely to be limited or there is a risk that the injury alleged will ultimately prove to be a threshold injury. In both cases, the risk is that the solicitor will perform a significant amount of work but be able to recover negligible fees. If it is commercially unsustainable for solicitors to act for claimants, it poses a serious issue of access to justice particularly for claimants who may be unable to secure legal representation if they are seen to be 'higher risk,' such as older clients who do not earn an income, or cases where a claimant is at risk of a finding of contributory negligence that will push an otherwise 'above threshold' case below the $75,000 threshold. We suggest that the review consider reducing the threshold to the previous figure of $50,000, noting that certain types of cases that the increased threshold was intended to exclude are excluded by other provisions, such as the threshold injury requirement or the inability to capitalise the entitlement to treatment and care into a lump sum. Alternatively, the review may wish to consider a proportionate approach, e.g., a reduction in the costs recoverable based on the extent to which the value of the claim falls below the threshold.

[23] Above n 24, pp 2-4.

		The Law Society has previously expressed its concerns, both to the Standing Committee on Law and Justice and SIRA, regarding the operation of clause 25 of the MAIR.[24] The Law Society has previously made submissions including case examples that illustrate the problematic application of clause 25 to fee arrangements between insurers and their legal representatives, which has the effect that, despite assisting in achieving significant savings to the scheme, insurers' solicitors may be required to write off or repay significant sums of legal costs. Recent experience of members has seen further such examples, set out below. It is relevant to note that in some of these case examples, claimants were either unrepresented, or occasionally represented. In our view, these examples illustrate the value of insurers' solicitors for the Scheme, and also that both that claimants and insurers require effective legal representation in order to both achieve balanced outcomes and protect the sustainability of the Scheme. Creating barriers to their involvement compromises those goals. Insurers' solicitors play an important role in claims management and investigation where claimants are unrepresented. Where claimants are represented, their solicitors advocate for their client's interests based on the instructions provided to them and the evidence they obtain on their clients' behalf, and insurers' solicitors serve an important counterbalancing function to test claimants' evidence and work towards outcomes that appropriately reflect the strengths and weaknesses of the parties' respective positions and claimants' legitimate entitlements. The value to the Scheme of that work ought to be recognised by review of recoverable legal costs and associated provisions to better reflect the cost of providing those services. **Case study 1** • Panel lawyers acted for over two years. • As a result of the subject accident, the claimant alleged he sustained a dislocation of the right sternoclavicular joint, significant right shoulder injury, multiple rib fractures, sternal fracture, loculated haematoma involving pectoralis muscle of the chest wall, cervical spine injury, thoracic spine injury, lumbar spine injury, right wrist fracture, right knee injury, PTSD and anxiety. • The insurer paid weekly benefits totalling $312,143.86

[24] See, e.g., Letter to State Insurance Regulatory Authority dated 21 November 2024, enclosed to Letter from the Law Society to the Hon. Greg Donnelly, MLC (Standing Committee on Law and Justice).

		• Panel lawyers conducted extensive investigations and advised on significant causation issues arising from pre-existing conditions. • The matter proceeded to a permanent impairment dispute where the claimant was assessed to have a 0% permanent impairment, increased to 5% by a subsequent review panel. • The claimant sought damages in excess of $957,000 and made a final settlement offer of $600,000 prior to the Commission damages assessment conference. • The Commission Member awarded damages of $44,781.77. • Saving to the Scheme was over $550,000. • The insurer was not permitted to pay over $47,000 of its panel lawyers' fees due clause 25. **Case study 2** • Panel lawyers acted for over two years. The claimant was largely unresponsive, required multiple follow ups to obtain co-operation and particulars, and resisted early attempts to settle without non-economic loss. • Panel lawyers managed a threshold dispute in the Commission and investigations into the claimant's alleged whole person impairment which involved extensive medical records, four expert medical reports, comprehensive submissions in reply, and an application for review of the threshold certificate. • Panel lawyers actively managed the damages dispute in the Commission, successfully advocated against the matter being placed in Stood Over list and obtained directions regarding the lodging of any impairment dispute. • The claimant sought damages of $473,000. • Matter settled for economic loss only for $50,000. • Saving to the Scheme over $423,000. • The insurer was not permitted to pay over $37,000 of its panel lawyers' fees due clause 25. **Case study 3** • Panel lawyers acted for eight months.

		• The claim involved a complex causation dispute due to extensive claims and medical history (GP records alone exceeded 850 pages). The claimant had had a prior cervical spine fusion at C6/7. • The insurer funded a C7/T1 fusion. If found to be related to the accident this would automatically give rise to a 25% permanent impairment and entitlement to non-economic loss. • The economic loss claim was complicated due to alleged self-employment, cash in hand receipts and lack of particulars. • The claimant was represented and unrepresented at various times. • Panel lawyers advised on the application of the Motor Accident Guidelines and AMA4 Guidelines to causation and obtained expert medical evidence which supported a decision by the Insurer the surgery was not causally related to the accident. • The claimant sought damages in the sum of $379,798. • The matter settled for economic loss only in the sum of $68,000. • Saving to the Scheme over $310,000. • The insurer was not permitted to pay over $27,000 of its panel lawyers' fees due clause 25. **Case study 4** • Panel lawyers managed the claim for over two years during which time extensive clinical records and economic loss evidence was obtained, two medico-legal experts were qualified on a joint basis. • The claimant sought damages of $250,000. • The matter settled for economic loss only in the sum of $50,000. • Saving to the Scheme over $200,000. • The insurer was not permitted to pay over $20,000 of its panel lawyers' fees due clause 25. **Case study 5** • Panel lawyers acted for two years.

		• Panel lawyers requested four sets of clinical records, particulars (including in relation to employment) and arranged joint psychiatric and orthopaedic assessments. • Panel lawyers engaged in several attempts at settlement discussions to progress the matter. • The claimant sought damages of $376,650. • This matter settled for economic loss only in the sum of $50,000. • Saving to the Scheme over $326,000 • The insurer was not permitted to over $14,000 of its panel lawyers' fees due clause 25. **Case study 6** • Panel lawyers acted for over three years. • The claimant lodged an application for common law damages for nervous shock and subsequently moved to the UK. • The insurer admitted liability subject to a 40% reduction for contributory negligence. • The matter proceeded to a permanent impairment dispute where the claimant was assessed to have 0% permanent impairment. • The claim was referred for assessment and involved eight preliminary conferences with a single Commission Member. • The claimant sought damages of $399,405.72. • The matter settled the day before the assessment conference for $10,000 inclusive of costs. • Saving to the Scheme over $390,000. • The insurer was not permitted to pay over $35,000 of its panel lawyers' fees due clause 25. **Case study 7** • Insurer's solicitors received instructions to act in a claim for damages in 2024.

		• The matter was complex due to the claimant's prior mental health history and alleged severe psychological symptoms arising from a minor collision. Fault was admitted. • The claimant sought damages for future economic loss in the sum of $400,000. • Extensive investigations were carried out into unmeritorious parts of the claim by the insurer's solicitors pursuant to the insurer's duty to deter fraud. • The insurer's solicitors contracted out and were paid hourly rates. The claim proceeded in the Commission and in 2026, the claimant's former solicitor ceased to act. • The unrepresented claimant then made an offer to the insurer of less than $50,000 which was accepted by the insurer and approved by the Commission. • As a result of clause 25, the insurer's solicitors had to refund to the insurer approximately $40,000 in paid legal costs and write off a further $5,000 of unbilled work in progress.
Scheme information, compliance and enforcement		
32.	What other matters (if any) should the review consider in relation to scheme information, compliance and enforcement? Please explain.	We understand that it is not the Commission's practice to review all assessment certificates for quality assurance, in contrast to the former Medical Assessment Service previously conducted by SIRA. Since that practice ceased, our members have noticed frequent repeated errors in certificates, including errors in the treatment of causation issues; entire sections of the certificate being left blank; and indications that not all relevant documents have been considered. More errors in certificates leads to more matters subject to review applications. The Law Society suggests that the review consider options for quality assurance of assessment certificates in order to reduce errors and promote assessor education. That may include a quality assurance process within the Commission, for example, such as the delegate reviewing a medical assessment decision before it is issued. Practitioners have also reported that in their experience, insurers may not disclose all materials in their possession at the time of issuing a 'liability notice' but instead confine their disclosure only to those materials relied upon for the decision in the notice. The review should consider means of promoting insurers' compliance with their obligation to

		disclose all information in their possession regardless of whether it has been relied upon for a liability denial and/or whether it assists the position reached by the insurer.[25]
33.	What other information (if any) should SIRA publish? Please explain.	No further comment.
34.	Are there opportunities to improve SIRA's compliance and enforcement powers? Please explain.	We encourage the review to give consideration to refining the requirements for insurers to give notice before terminating claimants' weekly benefits in situations where there is an allegation of fraud or non-entitlement to payment. The information provided to claimants in those situations should make clear that the claimant has the option to waive the notice period if they are prepared to concede that they are not or no longer entitled to payments; this would reduce accidental overpayments and alleviate the need to recover overpayments subject to proof of fraud.
35.	Are there opportunities to improve complaints handling under the scheme? Please explain.	Generally, our members report a lack of communication from SIRA throughout the complaints handling process, until a complaint 'outcome' is reached. Conversely, our members have acknowledged the increased pressure on the Scheme caused by complaints lodged by unrepresented claimants in particular which, with the advent of generative AI, have increased in length and volume and become more difficult to distil and address.
Point to point industry		
36.	What other issues (if any) should the review consider about the point to point industry and the CTP insurance scheme? Please explain.	No further comment.
37.	How should point to point industry vehicles (including taxis and rideshare vehicles) be charged for insurance under the scheme? Why?	No further comment.

[25] State Insurance Regulatory Authority Motor Accident Guidelines, cl 4.35(b).

CTP Care		
38.	Are there any other issues about CTP Care that the statutory review should consider? Please explain what they are (if any).	Our members suggest there appears to be opportunities lost for economies of scale and efficiencies (and therefore to lower the costs of managing the Scheme overall) by managing CTP Care and Lifetime Care and Support via separate departments, despite being funded in the same way.
39.	Do you think there is adequate oversight of CTP Care's claims management? Please explain.	As previously noted, the Law Society supports greater oversight of CTP Care and Lifetime Care and Support premium components and cost increases. This would allow for identification of any aspects of claims management process that may excessively contribute to increases in those levies that in turn impact premiums and affordability of insurance.
40.	Should 'Early by Agreement' arrangements be used more to transfer injured people to CTP Care? Why or why not? a. If yes, what would support the use of these arrangements? Please explain	Yes. In our members' experience, early transition to CTP Care is not well understood or actively encouraged and for this reason, the Law Society supports SIRA publishing clearer information about transition processes. In turn, insurers could be educated about offering early transition in appropriate cases.
Other issues		
41.	Are there any other issues that have not been covered in this issues paper that the statutory review should consider? Please explain what they are (if any).	The Law Society reiterates its support for the implementation of the balance of the recommendations set out in Clayton Utz' report of 22 September 2021.[26]

[26] Report of Statutory Review of the Motor Accident Injuries Act 2017, Clayton Utz, 22 September 2021.