CTP Review
Motor Accidents Insurance Regulation
State Insurance Regulatory Authority
Level 25, 580 George Street
Sydney NSW 2000

25 November 2016

By Email to: ctp_review@sira.nsw.gov.au

Dear Sir/Madam

Supplementary Submission: Insurer claims handling and dispute resolution in compulsory third party (CTP) motor accident insurance 2016

I refer to the joint legal profession submission on "CTP Review – claims handling and dispute resolution" dated 25 November 2016. The ALA makes the following submission in addition to the joint legal profession's response to the Discussion Paper "Insurer claims handling and dispute resolution in compulsory third party (CTP) motor accident insurance".

WHY ARE THERE DISPUTES?

Before turning to the twenty questions for discussion, it may be of assistance to take a step back and analyse why disputes arise. The discussion paper issued by SIRA conspicuously fails to address this fundamental question.

In the simplest terms, there is a dispute because a claimant asks for something (a medical treatment, assistance at home, income support) and the insurer says no.

Why does the claimant ask? In most instances because they have a need. In relation to the medical treatment, the need arises because a treating practitioner (GP or specialist or allied health professional) makes a recommendation for that treatment.

In the case of income support, the claimant asks because the claimant is not working and needs to eat, house him or herself and feed their family.

Faced with these demands, why would an insurer say no?

There are at least two reasons and any effort to fundamentally realign claims culture (as the discussion paper enthusiastically, but unconvincingly purports is going to happen) needs to address these fundamental reasons for conflict.

One basis for an insurer saying no is the belief that the claimant's request is unreasonable or unsupported by evidence or unsupported by the best evidence. It is acknowledged that some

claimants exaggerate. The extent to which this occurs is unmeasured. Some treating doctors recommend inappropriate treatment. Again, the prevalence is unmeasured.

A system in which the answer to every request must be "yes" will not contain costs. There clearly needs to be some mechanism for assessing the reasonableness of requests for payment and a dispute resolution mechanism.

However, things are not that simple in a privately underwritten scheme. The second basis for an insurer to say "no" is that the NSW CTP scheme involves large sums of money and extraordinary profits for what are now four private insurers. Over $2 billion is collected each year from the motorists of NSW. The more each CTP insurer says "no", the more of that money they get to keep. Ultimately the four CTP insurers are profit driven and the profits they yield are ultimately a reflection of their skill and success in saying "no".

Accordingly, those four CTP insurers devote vast energies and resources to saying "no" and to winning the disputes that are subsequently generated.

THE "EVIDENCE" TO SAY NO

Much is said about the CTP scheme relying on "evidence based medicine". However, for a good deal of their "evidence" the CTP insurers rely upon medico-legal practitioners with little or no clinical practice. Even those who have an extensive clinical practice are nonetheless carefully selected on the basis that they are the ones most likely to write reports that permit insurers to say no.

Each insurer maintains a list of "panel" doctors who are those approved by senior management. The primary criteria for getting onto this list and maintaining a position on the list is writing reports that the insurers can use in their battles with claimants.

Doctors and other allied health professionals who are not suspicious, prepared to interrogate and prepared to advocate for the insurer's position rather than the claimant's do not last long on the list. There is no place for the empathetic or unquestioning.

Nowhere within the Discussion Paper is there even acknowledgment that the insurers have ready access to a large pool of medico-legal opinion writers prepared to provide pro-insurer opinions. The fact that the Medical Assessment Service regularly rejects such opinions and reaches alternate conclusions is evidence of the existence of the bias of this group.
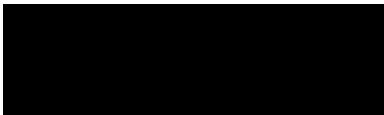
[It is an entirely different subject to analyse how some pro-insurer experts maintain a place on the MAS panel. Ongoing objections by the legal profession to MAS using doctors whose only medico-legal practice involves writing reports purely for the one side (the insurance industry) have been ignored. Specific doctors whom the legal profession believe do not meet the fairness and neutrality test that MAS should be imposing have been identified. MAS has never been prepared to audit doctors as to the balance of their practice and simply accepts each doctor's self-declaration that they have a balanced medico-legal practice. MAS continues to have on its panel one doctor who has admitted under cross-examination that it would be "rare" that he ever did a medico-legal assessment on behalf of a plaintiff.]

As long as insurers have access to "tame" medico-legal opinion to justify saying "no" then disputes will continue to arise. Fundamental to trying to lessen the level of disputation is to remove the biased medico-legal reporting from the system.
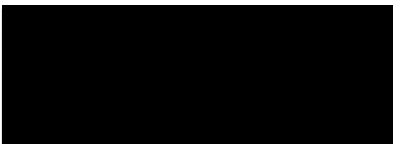
Rather than addressing this critical issue, the preferred approach from SIRA to reduce disputation appears to be (consistent with the current operation of Work Capacity Assessments in the workers compensation system) removing any scope to argue with or challenge the biased opinions of the insurer-paid experts. Rather than removing these opinions from the system, they are given decisive weight.

Thank you for the opportunity to respond to the Discussion Paper.

Yours sincerely

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