STATUTORY REVIEW OF THE MOTOR ACCIDENT INJURIES ACT 2017

Discussion Paper

CLAYTON UTZ

5 July 2021

www.claytonutz.com

CONTENTS

1. INTRODUCTION

Background

The *Motor Accident Injuries Act 2017* established a new scheme of compulsory third-party insurance and provision of benefits and support relating to the death of or injury to persons as a consequence of motor accidents in NSW (**Scheme**). The Scheme commenced on 1 December 2017.

The Scheme is set out in the Act, the Regulations made under the Act, and Guidelines issued by SIRA under the Act. It was the result of extensive consultation and deliberation on the part of the NSW Government, SIRA, the insurance industry, the legal profession, road users and other stakeholders as to the best way to reform the previous scheme to resolve a range of issues that had arisen within that scheme.

An important element of the Act was to require the Minister to review the Act, Regulations and Guidelines against the policy objectives of the Act and report to Parliament after the first 3 years of the new Scheme.

Clayton Utz and Deloitte are appointed by the Minister to undertake that review (**Review**). This discussion paper sets out some initial analysis of the Scheme and seeks feedback from stakeholders that will inform the Review.

The Review's terms of reference are set out in section 11.13 of the Act.

Some history relating to the Scheme

NSW's previous CTP scheme, under the *Motor Accidents Compensation Act 1999* (**1999 Scheme**), was almost entirely based on injured persons recovering lump-sum damages from persons at fault in a motor accident, as compensation for injury and resulting loss.[1]

Some years after its commencement, there were concerns that the 1999 Scheme was "*not serving injured road users as well as it could*".[2] Only 45 cents in each premium dollar was being paid to injured road users, with the rest going towards costs of administering the 1999 Scheme, paying the providers of services within the 1999 Scheme, and insurer profits.[3] The 1999 Scheme experienced an increase in fraudulent and exaggerated claims which led to increased premiums for road users.[4] Claims took between 3 and 5 years to be resolved, and there were community concerns about substantial annual premium price increases.[5]

The design of the current Scheme was intended to remedy these concerns; many of them are expressly referred to in the Act's legislated objectives.[6]

In its 2016 'Options Paper' for reforming the Scheme, the NSW Government outlined 4 alternative scheme designs for consideration. Of these, a "*hybrid no-fault, defined benefits scheme*", that retained some common law benefits, was selected for implementation.[7] The Scheme as ultimately set out in the legislation

---

[1] The 1999 Scheme still operates in respect of motor accidents that occurred before 1 December 2017.

[2] NSW Government, *On the Road to a Better CTP Scheme: Options for Reforming Green Slip Insurance in NSW*.

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Section 1.3(2) of the Act.

[7] NSW Government, *On the Road to a Better CTP Scheme: Options for Reforming Green Slip Insurance in NSW*, page 16.

is a 'hybrid' scheme in the sense that it provides for statutory benefits to support injured persons while retaining common law rights to claim compensation in certain cases. It also introduced a significant element of support for at-fault injured persons that was not present in the 1999 Scheme.

Minister Victor Dominello, in his speech on the second reading of the Motor Accident Injuries Bill 2017 in the NSW Parliament, said of the intended benefits of the "*new NSW compulsory third party [NCTP]*" Scheme:[8]

> "*Motorists can expect to see a gradual reduction in green slip premiums throughout the course of this year with the full reductions to be felt from day one of the new scheme. The NCTP will give people injured in accidents fast access to statutory benefits in the form of weekly income support and medical treatment and care. The focus of NCTP will be on rehabilitation of injured road users so they can return to good health sooner. The reforms will also improve the claims and dispute resolution process and arrest insurer super profits.*"

The bill was passed, and the Scheme began on 1 December 2017.

The Scheme was first reviewed in a report of the SCLJ dated February 2019. However, the Committee Chair noted that as the Scheme had come into effect approximately one year earlier, it was "*too early to comprehensively assess the performance of the scheme against its objectives*".[9]

Policy objectives of the Act

The policy objectives of the Act are set out in section 1.3(2) of the Act itself. They are reproduced below.

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.
Objective (b)	To provide early and ongoing financial support for persons injured in motor accidents.
Objective (c)	To continue to make third-party bodily insurance compulsory for all owners of motor vehicles registered in New South Wales.
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.
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.
Objective (f)	To deter fraud in connection with compulsory third-party insurance.
Objective (g)	To encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes.
Objective (h)	To ensure the collection and use of data to facilitate the effective management of the compulsory third-party insurance scheme.

The Scheme has a number of defining features in which Objectives (a) through (h) are manifest including, among other things, the provision of statutory benefits to provide income replacement ('weekly payments') and to fund treatment and care, frameworks to limit benefits for 'minor injuries' and to make benefits available

[8] New South Wales, *Second Reading Speech - Motor Accident Injuries Bill 2017 (NSW)*, Legislative Assembly, 9 March 2017.

[9] SCLJ, *2018 Review of the Compulsory Third Party Insurance Scheme*, February 2019, page vii.

to injured persons who are mostly or wholly at fault, a regime for internal review of insurer decisions and external resolution of disputes, mechanisms to regulate insurer profits directly, and an extensive role within the Scheme for the regulator, SIRA. Where statutory benefits for treatment and care are needed by an injured person beyond 5 years after the motor accident concerned, the 'relevant insurer' liable to pay the statutory benefits becomes the Lifetime Care and Support Authority and ceases to be the licensed insurer initially liable on the claim.

Approach to the Review

The terms of reference effectively require, for each Objective, an analysis of the particular framework in the Act, Regulations and Guidelines for implementation of the Objective, as well as of the features of the Scheme that limit achievement of the Objective.[10] This is necessary to consider whether the Objective remains valid and whether the terms of the Act, Regulations and Guidelines (that is, the framework) remain appropriate to secure the Objective. It is also necessary to measure the implementation of the Scheme against the Objectives and, as a first step to that end, to form a view as to the appropriate metrics – both quantitative and qualitative – to measure implementation.

Part 2 of this paper reproduces the Review's terms of reference.

Part 3 of this paper sets out for each Objective a summary of the legislative framework in the Act, Regulations and Guidelines for achieving the Objective and some observations on that framework,[11] and then poses questions to elicit feedback. There are general questions based directly on the terms of reference and targeted questions based specifically on the framework for each individual Objective.

Part 4 of this paper sets out a KPI framework to assess the extent to which the Scheme is achieving its intended objectives, developed from a preliminary review of available data on the implementation of the Scheme. The Review seeks feedback on the KPIs by reference to a set of 3 questions common to each Objective.

Appendix A to this paper is a collated list of all questions and **Appendix B** is a glossary of terms used in the paper.

This paper is the first stage in the Review. In the second stage of the Review, Clayton Utz and Deloitte will:

- review responses to this paper
- if considered necessary or appropriate, engage directly with stakeholders to ask questions arising out of written responses
- host targeted workshops to enable both discussion of particular issues identified in the course of the Review and specific questioning in light of written responses to this paper.

In the third stage of the Review, Clayton Utz and Deloitte will prepare a final report for the Minister, to be tabled in each House of Parliament by 1 December 2021.

Request for feedback

Clayton Utz and Deloitte wish to hear from stakeholders in order to gather information to assist in carrying out the terms of reference.

---

[10] In undertaking an analysis of this kind, it is important to bear in mind that the Objectives are inevitably, to some degree, at cross purposes and the legislation must strike a balance in pursuit of them.

[11] The summary of the legislative framework for each Objective is necessarily set out at a high level and presents only a simplified outline of the legislation. In order to understand the Scheme or any of its components fully, it is necessary to read the legislation itself. In addition, in many cases injured persons may have other sources of financial or other support available to them outside of the support provided through the Scheme. Those other sources of support are not considered in this paper.

The discussion and analysis in this paper is not exhaustive of the issues that may be considered or the questions on which feedback may be sought from stakeholders during the course of the Review. Stakeholders are encouraged to give feedback generally having regard to the terms of reference, including on any issues concerning the validity of the Objectives or on the framework to achieve them that are not addressed in this paper.

Clayton Utz and Deloitte have received and considered copies of submissions made by stakeholders to the Law and Justice Review, a Parliamentary committee inquiry into the Scheme which is currently underway.[12] In preparing submissions to the Review, stakeholders may choose to refer to, or incorporate by reference, their submissions to the Law and Justice Review to avoid unnecessary repetition of work already done.

Interested persons may consult SIRA's website for details on how to provide feedback to the Review, including submitting a response to this paper or registering interest in participating in targeted stakeholder workshops.[13]

David Gerber, Partner

Mark Wiese, Senior Associate

CLAYTON UTZ

[12] The submissions can be accessed at: https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2616

[13] https://www.sira.nsw.gov.au/hub/statutory-review-of-the-motor-accident-injuries-act-2017-1

2. TERMS OF REFERENCE

11.13 Review of Act

(1) The Minister is to review this Act (and the regulations and guidelines under this Act) to determine whether the policy objectives of the Act remain valid and whether the terms of the Act (and those regulations and guidelines) remain appropriate for securing those objectives.

(2) The review is to be undertaken as soon as practicable after the period of 3 years from the commencement of this Act and a report of the outcome of the review is be tabled in each House of Parliament within 12 months after the end of that period of 3 years.

(3) The review is to consider all aspects of the scheme established by this Act, including the following matters—

(a) the effectiveness of the scheme ensuring insurers are receiving a fair but not excessive profit margin,

(b) the general performance of insurers in the scheme,

(c) the timeliness of the provision of benefits to injured persons,

(d) the proportion of each dollar of premiums collected that directly benefits injured persons,

(e) whether further changes are needed to the scheme.

3. SCHEME DESIGN: LEGISLATIVE FRAMEWORK

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.

Legislative framework

Statutory benefits are payable by the 'relevant insurer' in respect of injuries to persons that result from motor accidents in NSW.[14]

Injured persons are entitled to statutory benefits for expenses incurred in connection with providing treatment and care for the injured person ('treatment and care expenses').[15] These expenses are the reasonable cost of treatment and care, and reasonable and necessary travel and accommodation expenses to obtain treatment and care (and travel and accommodation expenses incurred by a parent or carer if the injured person is under 18 years old).[16]

The focus of Objective (a) is on supporting post-accident recovery from injury, and not on monetary compensation for loss.

The statutory entitlement to benefits for treatment and care rather than reliance on injured persons' entitlement to compensation is intended to facilitate early and appropriate treatment and care, including for at-fault injured persons.

The Guidelines provide for insurer-approved treatment even before a claim is made.[17] However, this only applies in the first 28 days after the motor accident and is at the insurer's discretion.[18]

An injured person is entitled to statutory benefits for reasonable expenses incurred in employing a person to provide domestic services to the claimant's dependants, if the injured person provided those services before the accident.[19] However, these statutory benefits are not available if the services provided after the accident are provided gratuitously.[20]

The expenses incurred must be verified in accordance with the Guidelines through the provision of invoices or receipts.[21] Alternatively, treatment and care providers may directly invoice the relevant insurer.[22]

---

[14] Section 3.2(1) of the Act.

[15] Section 3.24 of the Act.

[16] Section 3.24(1) of the Act.

[17] Clause 4.74 of the Guidelines.

[18] Clause 4.75 of the Guidelines.

[19] Section 3.26 of the Act.

[20] Section 3.25 of the Act.

[21] Clause 4.102 of the Guidelines.

[22] Clause 4.103 of the Guidelines.

Subject to the Scheme's dispute resolution provisions, the Scheme relies on insurers to decide what treatment and care expenses will be supported for an injured person. Clause 4.99 of the Guidelines sets out the information the insurer must provide when making a decision to approve or decline a request for treatment or care.[23]

Minor injury

As a general proposition, an injured person is not entitled to receive statutory benefits for treatment and care expenses incurred more than 26 weeks after the accident if the person's only injuries were 'minor injuries'.[24]

The current definition of 'minor injury' is as follows, having regard to the provisions of both the Act and the Regulations:

> **Section 1.6 of the Act:**
>
> *(1) For the purposes of this Act, a minor injury is any one or more of the following—*
>
> *(a) a soft tissue injury,*
>
> *(b) a minor psychological or psychiatric injury.*
>
> *(2) A soft tissue injury is (subject to this section) an injury to tissue that connects, supports or surrounds other structures or organs of the body (such as muscles, tendons, ligaments, menisci, cartilage, fascia, fibrous tissues, fat, blood vessels and synovial membranes), but not an injury to nerves or a complete or partial rupture of tendons, ligaments, menisci or cartilage.*
>
> *(3) A minor psychological or psychiatric injury is (subject to this section) a psychological or psychiatric injury that is not a recognised psychiatric illness.*
>
> **Regulation 4 of the Regulations:**
>
> *(1) An injury to a spinal nerve root that manifests in neurological signs (other than radiculopathy) is included as a soft tissue injury for the purposes of the Act.*
>
> *(2) Each of the following injuries is included as a minor psychological or psychiatric injury for the purposes of the Act:*
>
> *(a) acute stress disorder,*
>
> *(b) adjustment disorder.*

It may be inferred from the limited period of statutory benefits available to persons with only 'minor injuries' that the defined term 'minor injury' is intended to capture injuries where optimum recovery or return to work or other activities is likely to occur within 6 months. As persons with only 'minor injuries' are disentitled from making a claim for damages against an at-fault owner or driver, it might also be inferred that 'minor injuries' are intended generally not to be associated with significant ongoing loss of earning capacity or significant ongoing pain, suffering, loss of amenities or loss of expectation of life such as might result in a substantial award of damages. Nevertheless, the term 'minor injury' in the Act is a technical term with a legal meaning and is not to be confused with a clinical assessment of severity or an assessment of the significance of the injury to the injured person themselves.

Under section 3.28(3) of the Act, and despite the general cessation of statutory benefits after 6 months for minor injuries, statutory benefits for treatment and care "*are payable in respect of minor injuries if the Motor*

[23] Clause 4.99 of the Guidelines.

[24] Section 3.28 of the Act.

Accident Guidelines authorise their payment."[25] Part 5 of the Guidelines authorise certain specific treatment and care expenses to be paid by insurers for minor injuries after 26 weeks if:[26]

- the treatment and care will improve the injured person's recovery;
- the insurer delayed approval for the treatment and care expenses; or
- the treatment and care will improve the injured person's capacity to return to work and/or usual activities.

Approximately 25% of persons with only 'minor injuries' continue to receive statutory benefits for treatment and care beyond 6 months, under the above exception to the 6-month limit.[27]

In February 2020, SIRA published a report into the 'minor injury' definition and outcomes of the framework for limited statutory benefits for persons with only 'minor injuries'.[28] The report outlined 28 next steps to address issues identified in the report or conduct further monitoring of outcomes. In the current Law and Justice Review, several stakeholders have drawn attention to concerns that they have about the minor injury framework.[29]

Injured persons who are at fault

The Act also provides that statutory benefits for treatment and care cease after 26 weeks if the accident was caused wholly or mostly by the fault of the person and the person was over 16 years of age.[30] An accident is taken to have been caused mostly by a person's fault if the person's contributory negligence was greater than 61%.[31]

This aspect of the Scheme necessarily limits achievement of Objective (a), which itself does not distinguish between treatment and care required by persons who are, or are not, at fault. In the current Law and Justice Review, insurers have expressed support for extending the period that at-fault injured persons are entitled to statutory benefits, whether for treatment and care only, or for both treatment and care and weekly payments (i.e. income replacement).[32]

Exceptions to the entitlement to statutory benefits for treatment and care

An injured person who is not an Australian citizen or permanent resident is not entitled to statutory benefits for treatment and care provided outside Australia.[33] Statutory benefits are not available if workers

---

[25] Section 3.28(3) of the Act.

[26] Clause 5.16 of the Guidelines.

[27] SIRA, *Review of Minor Injury Definition in the NSW CTP Scheme*, page 20.

[28] SIRA, *Review of Minor Injury Definition in the NSW CTP Scheme*.

[29] See submissions to the Law and Justice Review by the Insurance Council of Australia, NSW Law Society, NSW Bar Association and the Australian Lawyers Alliance.

[30] Section 3.28(1)(a) of the Act.

[31] Section 3.28(2) of the Act.

[32] See submissions to the Law and Justice Review by the Insurance Council of Australia and Suncorp.

[33] Section 3.33 of the Act.

compensation is payable, if the injury is to the at-fault driver or owner of an uninsured motor vehicle, or if the injured person committed a 'serious driving offence' that was related to the accident.[34]

Other elements of the framework

The Act and Guidelines are intended to facilitate vocational training and support, particularly through recovery plans and financial incentives and assistance for employers, with a view to the injured person returning to work or other activities.[35]

Also underpinning the framework for the achievement of this object are the provisions dealing with duties of claimants and insurers to act with good faith and to resolve a claim justly and expeditiously, and the duty of claimants to minimise loss caused by the injury.[36] Under the Guidelines, insurers and those acting on their behalf must manage claims consistently with the principle of proactively supporting claimants to optimise their recovery and return to work or other activities.[37] Compliance with this obligation is, as with all requirements of the Guidelines, a condition of each insurer's licence to issue third-party policies.[38]

Questions

General questions

1. Does this objective remain 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?
3. What is the evidence that the Scheme is, or is not, achieving this objective?
4. What changes (if any) should be made for the Act, Regulations and Guidelines to secure, or better secure, this objective?

Specific questions

In answering the above general questions, interested parties may wish to consider the following specific questions. Interested parties are asked to provide evidence (where available) in support of the answers.

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?
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?
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?
8. Does section 3.25 of the Act:

---

[34] Sections 3.35 - 3.37 of the Act.

[35] Sections 3.17, 3.41 of the Act; clauses 4.76 - 4.78 of the Guidelines.

[36] Sections 6.3 - 6.5 of the Act.

[37] Clauses 4.5 - 4.6 of the Guidelines.

[38] Section 10.7 of the Act.

(a) advance any of the objects of the Act; or

(b) limit achievement of any of the objects of the Act?

Minor injury

9. Should the defined term 'minor injury':

   (a) be changed; and

   (b) if so, be 'short-term benefits injury', or another term?

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?

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?

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

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

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?

Objective (b)

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

Legislative framework

Statutory benefits

The Act provides for statutory benefits in the form of weekly payments, payable by the 'relevant insurer' to an injured 'earner' who suffers a total or partial loss of earnings as a result of the injury.[39]

The focus of Objective (b) is on providing post-accident financial support, and not on monetary compensation for loss.

The statutory entitlement to weekly benefits rather than reliance on claiming damages for lost earnings is intended to facilitate early financial support, including for at-fault injured persons.

As of December 2020, 54% of claimants received weekly payments within 4 weeks of lodging a claim, 39% between 5 and 13 weeks, and 6% between 14 and 26 weeks.[40] 1% of claimants waited between 6 months and a year to receive weekly payments.[41] This compares favourably with the 1999 Scheme, where compensation for loss of income was only available upon the resolution of the claim, meaning there was a typical wait of 18 months to 5 years for income benefits.[42]

Weekly payments are not redeemable as a lump sum.[43] The payments are assessed based on factors such as how long it has been since the accident, the person's pre-accident weekly earnings, the person's post-accident earning capacity and the person's age.[44] The payments are indexed on a review date in accordance with the Indexation Order.[45] The calculation of weekly payments for students, apprentices, trainees and young people is also provided for in Schedule 1 to the Act and in the Guidelines.[46] There are prescribed maximum and minimum weekly payment amounts, which operate to limit the upper end of such amounts and ensure that all eligible injured persons receive a minimum weekly payment.[47]

The Act provides that weekly payments cease after 26 weeks if a person's injuries are 'minor injuries'.[48] In contrast to statutory benefits for treatment and care, there is no provision for the continuation of weekly payments after 26 weeks for persons who have only minor injuries. According to SIRA's analysis of Scheme

---

[39] Division 3.3 of the Act.

[40] SIRA, *CTP Insurer Claims Experience and Customer Feedback Comparison, December 2020*, page 6.

[41] Ibid.

[42] SIRA, *Submission to the Law and Justice Review*, November 2020, page 15.

[43] Section 3.42 of the Act.

[44] Sections 3.6 - 3.8 of the Act.

[45] Clauses 4, 4A of the Indexation Order.

[46] Clauses 5,6 of Schedule 1 to the Act; clause 4.54 of the Guidelines.

[47] Sections 3.9, 3.10 of the Act; regulation 7 of the Regulations.

[48] Section 3.11(1) of the Act.

data published in February 2020, approximately 76% of persons with only minor injuries "*had a positive indication of return to work*" at 26 weeks after a motor accident.[49]

The Act also provides that a person's weekly payments cease after 26 weeks if the accident was caused wholly or mostly by the fault of that person.[50] An accident is taken to have been caused mostly by a person's fault if the person's contributory negligence was greater than 61%.[51] For persons who are not considered to be at-fault but whose negligence contributed to the accident concerned, weekly payments are reduced after 26 weeks in proportion to the person's contributory negligence.[52]

If the injured person has a non-minor injury, and was not wholly or mostly at fault, the Act provides that weekly payments cease after 104 weeks unless the injured person has a pending damages claim, in which case weekly payments cease after 156 weeks (if permanent impairment is not >10%) or 260 weeks (if permanent impairment is >10%).[53] If the pending damages claim is withdrawn, settled or finally determined then the weekly payments cease.[54] There is also provision for the termination of payments when an injured person reaches retiring age,[55] or 12 months after retiring age if the injury happens after retiring age.[56]

The Act provides that there are no statutory benefits payable for gratuitous attendant care services.[57] Depending on the local availability of required attendant care services, and subject to other available sources of support, this may increase the risk of financial loss to the households of at least some injured persons. To this extent, it could be said that the exclusion of statutory benefits for gratuitous attendant care has the potential to cut across Objective (b).

There are obligations on injured persons to provide to the relevant insurer:[58]

- information about a change in circumstances
- medical certificates
- authorisations for medical practitioners to give the insurer information
- certificates of fitness for work
- declarations as to whether the person is engaged in any employment or voluntary work.

If the injured person does not comply with these obligations, then the insurer may suspend weekly payments provided it has complied with the notice provisions in the Act and the Guidelines.[59]

---

[49] SIRA, *Review of Minor Injury Definition in the NSW CTP Scheme*, page 27.

[50] Section 3.11(1) of the Act.

[51] Section 3.11(2) of the Act

[52] Section 3.38 of the Act.

[53] Section 3.12(2) of the Act.

[54] Section 3.12(3) of the Act.

[55] 'Retiring age' is, essentially, the age at which a person would be eligible to receive an age pension: section 3.13(3) of the Act.

[56] Section 3.13 of the Act.

[57] Section 3.25 of the Act.

[58] Sections 3.14, 3.15, 3.18 of the Act; clauses 4.62 - 4.67 of the Guidelines.

[59] Section 3.19 of the Act; clause 4.57 of the Guidelines.

The Act and Guidelines provide that insurers must require injured persons who receive weekly payments to undertake reasonable and necessary treatment, rehabilitation or vocational training.[60] The Act provides that where a claimant has received weekly payments amounting to more than they were entitled, they may be asked to make repayments.[61] The Act also provides for weekly payments to injured persons residing outside Australia in certain circumstances.[62]

Damages

As to damages (i.e. lump-sum compensation), the Act regulates "*an award of damages that relates to the death of or injury to a person caused by the fault of the owner or driver of a motor vehicle in the use or operation of the vehicle*."[63] Persons with minor injuries only are not entitled to claim damages, and persons with non-minor injuries but <10% permanent impairment cannot claim damages for non-economic loss and cannot make a claim for damages until at least 20 months after the accident.[64]

The Act places limits on the damages that can be awarded for both economic and non-economic loss.[65] The Act imposes a 3-year limitation period on commencing court proceedings in respect of a claim.[66]

The Act provides for assessment of claims (or exemption from a claims assessment) by the PIC before commencement of proceedings, and governs medical assessments for damages claims.[67]

In relation to damages claims, the Guidelines provide greater detail about practical matters such as requests for concession of degree of permanent impairment, late claims, notices of claims, liability decisions, and requirements for decisions as to non-economic loss.[68] The Guidelines also contain rules governing offers of settlement and the finalisation of claims.[69]

Underpinning the framework for the achievement of Objective (b) are also the provisions dealing with duties of claimants and insurers to act with good faith and to resolve a claim justly and expeditiously, and the duty of claimants to minimise loss caused by the injury.[70] These duties apply to all claims, whether for statutory benefits or damages.

Questions

General questions

15. Does this objective remain valid?

---

[60] Section 3.17 of the Act; clauses 4.82 - 4.87 of the Guidelines.

[61] Section 3.20 of the Act.

[62] Section 3.21 of the Act.

[63] Section 4.1(1) of the Act.

[64] Sections 4.4, 4.11, 6.14(1) of the Act.

[65] Sections 4.5, 4.6, 4.13 of the Act.

[66] Section 6.32(1) of the Act.

[67] Division 7.6 of the Act.

[68] Clauses 4.108 - 4.122 of the Guidelines.

[69] Clauses 4.123 - 4.127 of the Guidelines.

[70] Sections 6.3 - 6.5 of the Act.

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?

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

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

Specific questions

In answering the above general questions, interested parties may wish to consider the following specific questions. Interested parties are asked to provide evidence (where available) in support of the answers.

Weekly payments

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

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?

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?

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)?

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?

Minor injury

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

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

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?

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

28. Does the 20 month period:

    (a) encourage early resolution of claims?

    (b) deter injured persons from making damages claims?

    (c) effectively deter fraud?

29. Does the 20 month period benefit:

    (a) injured persons;

    (b) insurers; or

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

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%?

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

Note: some questions relating to Objective (a) are relevant to Objective (b) but are not repeated here.

Objective (c)

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

Legislative framework

Division 2.1 of the Act has the effect that CTP insurance is compulsory for NSW motorists. It provides that it is an offence for a person to use an uninsured motor vehicle on a road, or for a person to cause or permit another person to use an uninsured motor vehicle on a road.[71] The maximum penalty for such an offence is 50 penalty units.[72] A motor vehicle cannot be registered without evidence of CTP insurance,[73] and the insurance may only be cancelled in defined circumstances.[74]

SIRA has stated, in relation to Objective (c), that over "*5.7 million Green Slip policies are sold in NSW each year. Customers are required to buy a new Green Slip prior to being able to register their motor vehicle. Customers can purchase a Green Slip by obtaining a quote online or over the phone through a licensed insurer.*"[75]

Questions

General questions

32. Does this objective remain valid?

33. 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?

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

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

[71] Section 2.1 of the Act.

[72] Section 2.1 of the Act.

[73] Section 2.6 of the Act.

[74] Section 2.8 of the Act.

[75] SIRA, *Submission to the Law and Justice Review*, November 2020, page 15.

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.

Legislative framework

Objective (d) is to keep CTP insurance premiums affordable through two means:

1. by ensuring that profits achieved by insurers do not exceed the amount that is sufficient to underwrite the relevant risk
2. by limiting benefits payable for minor injuries.

The framework to keep premiums affordable through the first of these means is implemented through:

- SIRA's power to reject premiums and regulate the profit assumptions built into them[76]
- risk equalisation arrangements under section 2.24 of the Act
- SIRA's power directly to regulate profits that are realised.[77]

There are numerous other provisions of the Act that could be said to have, as one of their aims, keeping CTP premiums affordable. However, the Review's focus is on the two means identified in Objective (d) for keeping premiums affordable.

The Review understands that it is widely accepted that premiums are lower under the current Scheme than under the 1999 Scheme and that therefore premiums are more affordable than before the commencement of the Act.

Minor injury

The framework to keep premiums affordable by limiting benefits payable for 'minor injuries' was discussed in the analysis of Objectives (a) and (b). Persons with only 'minor injuries' are excluded from claiming damages and have a lesser entitlement to weekly payments and statutory benefits for treatment and care than other injured persons.

It is notable that Objective (d) refers to "*limiting benefits payable for minor injuries*" and does not use the defined term 'statutory benefits'. This means that the exclusion of persons with only 'minor injuries' from claiming damages – and not only the limited access to statutory benefits – should be regarded as part of the framework to secure this objective. Given the exclusion of damages claims, Objective (d) does not *require* that access to statutory benefits also be limited for persons with 'minor injuries'. However, any proposed changes to the 'minor injury' framework should be considered against Objective (d).

The Review intends to consider the extent to which the limitations on benefits for 'minor injuries' within the Scheme (which apply only to persons whose only injuries are 'minor injuries', and not to minor injuries generally) are keeping premiums affordable.

[76] Division 2.3 of the Act.

[77] Section 2.25 of the Act; Part 2 of Schedule 4 to the Act.

Premium regulation

The Act provides that insurance premiums for third-party policies must be charged in accordance with Division 2.3 of the Act.[78] As a condition of the insurer's licence under the Act, the insurer must file with SIRA the premium it intends to charge, in the form prescribed in the Guidelines.[79] SIRA may reject a filed premium if it is of the opinion that the premium is excessive or inadequate or does not conform to the relevant provisions of the Guidelines.[80]

Insurers are required to disclose to SIRA the profit margin on which a filed premium is based, as well as the actuarial basis for its calculation.[81] Under clause 1.59 of the Guidelines, the maximum assumed profit margin allowed when determining premiums is 8% of the proposed average gross premium, subject to SIRA's discretion to allow a higher margin in particular circumstances.

It follows from these provisions that SIRA considers that a profit margin of 8% is sufficient for insurers to underwrite their risk in the Scheme for the purposes of Objective (d). Subject to the exercise of SIRA's discretion under the Guidelines, insurers are not permitted to set premiums to achieve a profit margin higher than 8%. Regulating insurer profit in this way at the point of filing premiums is the first step in securing Objective (d) insofar as it relates to insurer profits.

Under section 2.23(2) of the Act, SIRA is to assess filed profit margins and their actuarial bases, and include a report on the assessment in its annual report.

Risk equalisation

The Act makes provision for a REM to achieve "*an appropriate balance between the premium income of an insurer and the risk profile*" of policies issued by the insurer.[82] Before commencement of the REM on 1 July 2017 (under the 1999 Scheme), an inappropriate balance was understood, among other things, to be a source of excessive profit for some insurers.[83]

The Act allows for the making of regulations as to arrangements for allocation of high and low risk third-party policies, arrangements for the adjustment of premiums and allocation and transfer of premiums among insurers, and arrangements for the adjustment of the costs of claims and for the allocation and transfer of those costs among insurers.[84] Section 2.24(7) of the Act provides that an arrangement under equivalent provisions in the 1999 Scheme in force on commencement of the Act is taken to be an arrangement under the current Scheme. Therefore, the REM in force within the Scheme is the REM that commenced operation on 1 July 2017 and continued in force upon commencement of the Act.[85]

The REM operates by adjusting the allocation of premiums collected on relatively high-risk policies among insurers (thus requiring insurers to transfer premium income amongst themselves). The effect of this is to

---

[78] Sections 2.19, 2.20 of the Act.

[79] Section 2.21 of the Act; clauses 1.9 - 1.14 of the Guidelines.

[80] Section 2.22 of the Act.

[81] Section 2.23(1) of the Act.

[82] Section 2.24(1) of the Act.

[83] SIRA, *Reforming insurer profit in compulsory third party (CTP) motor vehicle insurance: Discussion paper*, November 2016, page 10.

[84] Section 2.24(2) of the Act.

[85] SIRA, *Review of the Risk Equalisation Mechanism (REM)*, July 2019, page 6.

balance across CTP insurers the cross-subsidies between low-risk and high-risk third-party policies.[86] This is intended to:[87]

- remove disincentives on insurers to market their product to high-risk customers (to reduce the risk of collecting an amount of premium on high risks that needs to be cross-subsidised by low risks, but which is out of proportion to the low risks actually written by the insurer to provide that cross-subsidisation); and
- reduce the ability of insurers to enhance profits by selectively writing only good risks (which could result in collecting an amount of premium that can cross-subsidise high risks, but which is out of proportion to the high risks actually written by the insurer that need cross-subsidisation).

SIRA published a review of the REM in July 2019. The review concluded that "*some of the objectives of the REM are already being met and some are indeterminate as yet, but there is no evidence of any outcomes that are contrary to expectations*", although it was "*too early to measure whether insurer profitability is more uniform or more diverse than previously*".[88]

Profit regulation

Section 2.25 of the Act gives SIRA the power to reduce insurer profits directly by requiring adjustments to past or future premiums, or payments by insurers into the SIRA Fund.[89]

The provisions of section 2.25 require (in some circumstances) or allow (in other circumstances) SIRA to undertake a review of premium income of insurers depending on a comparison of 'average realised underwriting profits' of insurers against 'average filed profits of insurers' (where filed profit is the estimated underwriting profit on which filed premiums are based). To give effect to these provisions, SIRA would have to make this comparison annually.

The Guidelines may make 'special arrangements' for adjusting insurer profit under section 2.25.[90] To date, SIRA has not published guidelines for the purposes of section 2.25.

Part 2 of Schedule 4 to the Act sets out a broadly similar regime for adjusting insurer profits derived from third-party policies issued during the 'transition period' (being the period commencing on 1 December 2017 and ending on a date to be prescribed by the regulations on the advice of SIRA). Detailed provisions governing the adjustment of profits under Part 2 of Schedule 4 are set out in the TEPL Guidelines. These provisions require annual preparation of a report by the appointed 'Scheme Actuary' into the industry-wide profit margin for concluded 'Accident Periods' (except the most recently concluded Accident Period at any given time). If the industry profit margin for a given Accident Period is outside the range of 'reasonable profit'[91] set by SIRA (currently 3%–10% of premium for the Accident Period[92]), then SIRA may proceed to a further assessment of industry-wide profit margin taking into account individual insurer contributions to aggregate profit as well as any allowances granted to insurers by SIRA under the TEPL Guidelines in respect of innovations implemented to advance the objects of the Act. If, upon this further assessment, the

---

[86] Ibid page 5.

[87] Ibid page 3.

[88] Ibid page 12.

[89] Section 2.25 also provides for adjustment premiums, or payments from the SIRA Fund to insurers, effectively to increase insurer profits. However, having regard to the terms of Objective (d), this discussion is focused on SIRA's power to reduce insurer profits.

[90] Section 2.25(2) of the Act.

[91] Clause 2(9) of Part 2 of Schedule 4 to the Act.

[92] Part 2 (definitions of 'Excess Loss Threshold' and 'Excess Profit Threshold') of the TEPL Guidelines.

industry-wide profit is above 10%, then SIRA may require insurers whose individual profit is above that level to pay money into the SIRA Fund which is then used to reduce the Fund Levies payable by motorists for third-party policies, thus reducing both the amount of profit derived by insurers from policies in force in a given Accident Period and the cost of CTP insurance to motorists by an amount and for a period determined by SIRA. The aggregate reduction in Fund Levies would be equal to the amount paid into the SIRA Fund by insurers.

Importantly, given the long-tail nature of CTP insurance, insurer profits in a given Accident Period are likely to be assessed annually under the TEPL Guidelines on multiple occasions. Under the TEPL Guidelines, if insurer profit is assessed as being outside the range of 'reasonable profit', then SIRA may only proceed to make adjustments to insurer profits if it is satisfied either that:[93]

- 95% or more of claim payments relating to the Accident Period have been made; or
- when 95% of claim payments have been made, insurer profit will still be outside the allowed range.

An Accident Period is likely to have to mature for some years before either of these criteria could be satisfied.

In the TEPL analyses undertaken in 2020, there were insufficient claims for the 2018 Accident Period (the first Accident Period of the Scheme) and SIRA deferred any decision as to whether to activate TEPL to recover excess profit. In recent submissions to the Law and Justice Review, SIRA stated that it was currently awaiting actuarial advice as to whether to trigger the next steps in the TEPL process for the 2018 and 2019 Accident Periods.[94]

The provisions of Part 2 of Schedule 4 to the Act are not identical with section 2.25 of the Act, with the consequence that any guidelines for profit adjustment under section 2.25 may not be able to put in place exactly the same mechanism that is in place under the TEPL Guidelines. The Review proposes to consider whether section 2.25 requires any amendments, including to clarify its operation or to align its provisions with those of Part 2 of Schedule 4 to the Act.

Questions

General questions

36. Does this objective remain valid?

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?

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

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

Specific questions

In answering the above general questions, interested parties may wish to consider the following specific questions. Interested parties are asked to provide evidence (where available) in support of the answers.

---

[93] Clause 3.8(c) of the TEPL Guidelines

[94] SIRA, *Standing Committee on Law and Justice 2020 Review of the Compulsory Third Party Insurance Scheme: Pre-hearing questions for SIRA*, page 1.

40. Objective (d) identifies two means of keeping premiums affordable – regulating insurer profits and limiting benefits for minor injuries.

    (a) Should this objective be expanded to include other means of keeping premiums affordable?

    (b) If so, what other means should be considered and why?

41. Does 8% exceed, or not exceed, the amount of profit that is sufficient to underwrite the relevant risk?

42. Are any aspects of the TEPL mechanism not expected (when activated) to secure the objective of keeping premiums affordable by regulating insurer profits?

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?

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 to the Act?

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.

Legislative framework

Objective (e) comprises two separate but related objectives:

1. to promote competition and innovation in the setting of premiums

2. to provide SIRA with a role to ensure the sustainability and affordability of the Scheme and fair market practices.

SIRA's role

SIRA's role in the Scheme is significant. Insurers who wish to issue certificates of insurance under the Scheme are required to hold a licence granted by SIRA.[95] Such licences have conditions as prescribed by the Act or the Regulations and as imposed by SIRA, including for the purpose of the efficiency of the Scheme generally.[96] The statutory conditions include requirements as to filings, market practices, business plans, and the provision of information to SIRA.[97] However, conditions cannot be likely to give an insurer a competitive advantage or require an insurer to obtain a share of the market.[98] SIRA is responsible for a number of functions in relation to licences and licensed insurers, such as assignment, suspension and cancellation of licences,[99] and supervision of licensed insurers under the provisions of Division 9.2 of the Act.

Under section 9.10 of the Act in Division 9.1 ("*Licensing of insurers*"), if SIRA is satisfied that an insurer has breached the conditions of its licence, or the Act, the Regulations or the Insurance Industry Deed,[100] then SIRA has the power to issue a letter of censure to the insurer or impose a civil penalty on the insurer up to $110,000. SIRA has asked the Review to consider the terms of section 9.10 of the Act, including whether improvements may be made to ensure efficient and effective enforcement of insurers' obligations. Although section 9.10 gives SIRA the power to impose a civil penalty, before doing so SIRA must proceed through several steps including taking advice from a 'special committee' of the Chairperson of SIRA's Board, a nominee of the Insurance Council of Australia and another person jointly nominated by SIRA and the Insurance Council of Australia, and give the insurer an opportunity to make written submissions on the matter.

Although discussed here in the section addressed to Objective (e), SIRA's power under section 9.10 is relevant to other Objectives as well. The Review will consider section 9.10 of the Act as an element of the framework for SIRA's role in relation to the Objectives generally. In addition to the questions in this paper

---

[95] Division 9.1 of the Act.

[96] Section 9.6 of the Act.

[97] Sections 2.21, 9.18, 9.23 of the Act; Parts 2, 3 of the Guidelines.

[98] Section 9.7 of the Act.

[99] Sections 9.8, 9.9, 9.11 of the Act.

[100] The Insurance Industry Deed is an agreement between the Minister on behalf of the State, SIRA, licensed insurers and other persons (if any) with respect to the third-party insurance scheme and the Nominal Defendant scheme under the Act: section 1.4(1) of the Act.

which relate to each Objective specifically, the Review would welcome feedback from all interested persons on this aspect of the Scheme.

SIRA is required under the Act to monitor and determine the insurers' respective market shares.[101] Insurers must retain or lodge with SIRA certain accounts, returns and other documents.[102] SIRA can audit or inspect records relating to the insurers' business and financial positions, to determine whether insurers are carrying out their CTP insurance businesses "*effectively, economically and efficiently*".[103] The Act also provides for SIRA to apply to the Supreme Court of NSW to make orders it considers necessary or desirable for the purpose of protecting the interests of policyholders where the insurer is not able to meet its liabilities.[104] SIRA is also able to approve government bodies as self-insurers.[105]

SIRA has wide-ranging functions under the Act in relation to monitoring the operation of the Scheme, advising the Minister of the administration, efficiency and effectiveness of the Scheme, publicising information, investigating complaints about premiums, market practices and claims handling, investigating claims to detect and prosecute fraudulent claims, keeping the Guidelines under review, providing an advisory service to assist claimants, and providing funding.[106]

Section 2.22(1) of the Act provides that SIRA may reject premiums proposed to be charged by insurers if the premium is excessive or inadequate or if they do not conform to the relevant provisions of the Guidelines. To promote competition and innovation in the Scheme, SIRA allows risk-based pricing under the Guidelines but requires this to be within limits to keep premiums affordable.[107] On this basis, SIRA reviews insurers' pricing within a framework not only of "*technical (actuarial) pricing*" but also non-technical considerations including business plans and growth strategies, responses to pricing by competitors, market segmentation and distribution strategies, and innovation and efficiencies in insurers' business models.[108] Part 1 of the Guidelines sets out detailed provisions governing the filing of premiums by insurers, including the assumptions to be built into filed premiums and the factors and analyses on which they must be, or are allowed to be, based.

Risk equalisation

The Act makes provision for a REM to achieve "*an appropriate balance between the premium income of an insurer and the risk profile*" of policies issued by the insurer.[109] According to SIRA, the REM in operation under the Act has "*the primary aim of creating a more competitive*" CTP market in NSW,[110] and "*enables insurers to receive a fair premium for each vehicle while simultaneously enabling all premiums paid by*

[101] Section 9.17 of the Act.

[102] Section 9.21 of the Act.

[103] Section 9.22 of the Act.

[104] Section 9.25 of the Act.

[105] Division 9.3 of the Act.

[106] Section 10.1 of the Act.

[107] Clause 1.5 of the Guidelines.

[108] Clause 1.7 of the Guidelines.

[109] Section 2.24 of the Act.

[110] SIRA, *Review of the Risk Equalisation Mechanism (REM)*, July 2019, page 3.

vehicle owners to meet the affordability or social equity requirements of the scheme."[111] The operation of the REM was outlined in the discussion of Objective (d).

Point to point industry

Special Guidelines apply to the determination of CTP premiums for taxis and hire vehicles.[112] SIRA has recently consulted on new Point to Point Guidelines intended to commence by 1 December 2021.[113] The new guidelines are intended to "*enable more equitable pricing of premiums for the P2P industry through tailored agreements that more accurately reflect the risk that a policy holder's vehicle brings to the scheme.*"[114] The guiding principles developed by SIRA in consultation with stakeholders are that CTP premiums in the point to point industry should be flexible, sustainable and affordable.[115]

NSW Taxi Council advocates for change such that there be "*no commercial disparities between Taxis and Rideshare*"[116] and has expressed a concern that the current reform agenda for the point to point industry will not address commercial disparities for small business operators in the industry.[117]

Fair market practice principles

Under section 9.16 of the Act, the Guidelines may deal with the issue of third-party policies by licensed insurers. Part 2 of the Guidelines, made under section 9.16, sets down principles for insurers to follow to advance the object of ensuring fair market practices. These include requirements to act in good faith, not to unfairly discriminate, to engage in transparent and practical processes and business practices, and to make CTP policies accessible and available to all customers.[118] Part 2 of the Guidelines sets out detailed provisions as to what these principles mean for insurer conduct.

TEPL Guidelines

The TEPL Guidelines, consistently with clause 4A of Part 2 of Schedule 4 to the Act, allow for an 'innovation support' factor to be allowed when determining adjustments to insurer profits derived from third-party policies issued during the transition period.119 'Innovation support' is a percentage of profit up to 3% which is excluded from the calculation of an insurer's profit for the purposes of profit adjustments, where the insurer has implemented an innovation approved by SIRA for 'innovation support'. In principle, the 'innovation support' mechanism in the TEPL Guidelines is capable of promoting innovation in the setting of premiums.

---

[111] Ibid.

[112] Motor Accident Guidelines - Determination of insurance premiums for taxis and hire vehicles, 2018.

[113] SIRA, *Proposed Draft Motor Accident Guidelines to support model for consultation*, 2021.

[114] SIRA, *CTP for taxis and hire vehicles in the point to point industry*, February 2021, page 3.

[115] Ibid page 4.

[116] NSW Taxi Council, *Submission to the Law and Justice Review*, page 16.

[117] SCLJ, *Hearing Transcript*, 25 May 2021, page 17 (Mr Rogers).

[118] Clause 2.11 of the Guidelines.

[119] Part 8 of the TEPL Guidelines.

Questions

General questions

45. Does this objective remain 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?

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

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

Specific questions

In answering the above general questions, interested parties may wish to consider the following specific questions. Interested parties are asked to provide evidence (where available) in support of the answers.

Competition on premium

49. To what extent do CTP insurers compete on premium in the NSW market?

50. How can the framework in the Act, Regulations and Guidelines better promote competition on premium in the NSW market?

Innovation in premium setting

51. What innovations in premium setting would benefit the Scheme?

52. Does the framework in the Act, Regulations or Guidelines need to change to allow or encourage those innovations?

Point to point industry

53. Are there commercial disparities (particularly for small business operators) in the point to point industry?

54. If so:

    (a) to what extent will the current reforms to determination of CTP premiums for taxis and hire vehicles address them?

    (b) are there innovations in premium setting that could further address them?

SIRA's role in relation to sustainability, affordability and fair market practices

55. Is the framework which defines SIRA's role in relation to sustainability, affordability and fair market practices adequate and appropriate to enable SIRA to take steps to ensure that these aims are achieved?

Objective (f)

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

Legislative framework

There are a range of provisions in the Act, Regulations and Guidelines that are directed to securing Objective (f), including:

- the 'minor injury' framework in Parts 3 and 4 of the Act
- Division 6.6 ("*Fraud in relation to claims*") in Part 6 of the Act
- Division 10.1 ("*Functions of SIRA*") in Part 10 of the Act
- certain claims handling provisions in the Guidelines and in Part 5, Division 4 of the Regulations.

Minor injury

The speech by Minister Dominello on the second reading of the Motor Accident Injuries Bill 2017 in the Legislative Assembly included reference to the aspects of the Scheme intended to help to deter fraud. These aspects included the shift to statutory benefits only for minor injuries:[120]

> "*Importantly, the bill is also designed to reduce fraudulent and exaggerated claims. Fraud and exaggeration currently costs New South Wales motorists as much as $400 million per year and adds about $75 to the cost of each green slip. Parts 3 and 4 of the bill will substantially reduce opportunities for fraudulent and exaggerated claims by providing statutory benefits for soft tissue and minor psychological injuries for up to six months and removing access to the common law system.*"

The 'minor injury' framework was discussed in this paper against Objectives (a) and (b). Although not reflected in express terms in the drafting of the framework, the restricted period of statutory benefits and abolishment of damages for persons with only minor injuries is an element of the broader framework to secure Objective (f).

SIRA considers that the 'minor injury' framework "*has successfully reduced the ability for people to abuse the system*."[121]

Fraud in relation to claims

Under section 6.39 in Division 6.6 of the Act, CTP insurers must take all such steps as may be reasonable to deter and prevent the making of fraudulent claims.

Division 6.6 also sets out certain offences and penalties for dishonest conduct, and provisions that may relieve claimants or insurers from liabilities to the extent that they would otherwise be increased by dishonest conduct.

The Explanatory Note to the Motor Accident Injuries Bill contained the following description of the intended provisions in Division 6.6 relating to fraudulent claims, insurers' duties, and penalties:[122]

---

[120] New South Wales, *Second Reading Speech - Motor Accident Injuries Bill 2017 (NSW)*, Legislative Assembly, 9 March 2017.

[121] SIRA, *Submission to the Law and Justice Review*, November 2020, page 18.

[122] Explanatory Note, Motor Accident Injuries Bill 2017 (NSW), page 7.

"***Division 6.6 Fraud in relation to claims***

This Division contains provisions relating to fraudulent claims, including a requirement for licensed insurers to take reasonable steps to deter and prevent fraudulent claims. The Division also makes it an offence to knowingly make a false and misleading statement in relation to a claim or to obtain a financial advantage by deception in connection with the motor accidents injuries scheme. The maximum penalty for an offence is 500 penalty units ($55,000) or 2 years imprisonment, or both. The Division also provides for a right of recovery against a person who obtains a financial benefit by means of a fraudulent claim."

Functions of the Authority

SIRA's functions under section 10.1(1) of the Act include to "*investigate claims and detect and prosecute fraudulent claims*".

Claims handling provisions

The claims handling provisions of the framework are set out in:

- the Guidelines, particularly Part 4 made under section 6.1 of the Act dealing with "*the manner in which insurers and those acting on their behalf are to deal with claims*". Clause 4.6(d) of the Guidelines requires insurers and those acting on their behalf to deal with claims in a manner that is consistent with the principle of detecting and deterring fraud; and

- regulation 14 (Claims exempt from assessment) in Division 4, Part 5 of the Regulations. To assist insurers to handle damages claims suspected to affected by a claimant's fraudulent conduct, regulation 14(d) in Division 4 of Part 5 provides that the following kind of claim is exempt from assessment under Division 7.6 of the Act:[123]

  "*a claim in connection with which the insurer has, by notice in writing to the claimant, alleged that the claimant has engaged in conduct in contravention of section 6.41 (Fraud on motor accidents injuries scheme) of the Act.*"

Questions

General questions

56. Does this objective remain valid?

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?

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

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

Specific questions

In answering the above general questions, interested parties may wish to consider the following specific questions. Interested parties are asked to provide evidence (where available) in support of the answers.

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:

[123] Regulation 14(d) of the Regulations.

(a) the 'minor injury' framework?

(b) the penalties for fraud?

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

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

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

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?

Objective (g)

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

Legislative framework

Statutory benefits: resolution of claims

A claim for statutory benefits is made by giving notice to the 'relevant insurer' of the claim.[124] The Guidelines contain detailed provisions governing the notification of statutory benefits claims, including to the effect that notification may be given by using SIRA's online claim submission form.[125]

If the claim is not made within 28 days of the accident, then statutory benefits are not payable in respect of the period after the accident but before the claim was notified.[126] There is no mechanism for relief for an injured person even if they miss this deadline through no fault of their own.

Notification must in any event be made within 3 months of the motor accident concerned.[127] A claim may only be made after the 3-month time limit if the claimant provides a 'full and satisfactory' explanation for the delay and the claim is either made within 3 years of the accident or is in respect of death, or injury resulting in permanent impairment >10%.[128]

The Guidelines give detail to the obligation on claimants to submit information enabling verification of the motor accident concerned.[129] The insurer is not obliged to deal with a claim for statutory benefits until such time as the claimant complies with these obligations or provides a 'full and satisfactory explanation' for non-compliance (where an explanation is not 'satisfactory' unless a reasonable person in the position of the claimant would have failed to comply with the obligation[130]).[131]

Subject to modification by the Regulations, within 4 weeks of the claim being made the relevant insurer must notify the claimant whether or not it accepts liability to pay statutory benefits in the initial 26-week period after the accident.[132] Again subject to the Regulations, within 3 months of the claim being made the relevant insurer must notify the claimant whether or not it accepts liability to pay statutory benefits beyond 26 weeks.[133] This will depend on the insurer's assessment of fault and the classification of the claimant's injuries as minor injuries or otherwise. The relevant insurer must begin payment of statutory benefits immediately after accepting liability to pay.[134]

---

[124] Section 6.12(1) of the Act.

[125] Clause 4.18(a) of the Guidelines.

[126] Section 6.13(2) of the Act.

[127] Section 6.13(1) of the Act.

[128] Section 6.13(3) of the Act.

[129] Clauses 4.11 - 4.13 of the Guidelines, issued pursuant to section 6.8 of the Act.

[130] Section 6.2(2) of the Act.

[131] Section 6.9 of the Act.

[132] Section 6.19(1) of the Act.

[133] Section 6.19(2) of the Act.

[134] Section 6.19(6) of the Act.

The claimant must co-operate fully with the insurer for the purpose of giving the insurer sufficient information to be satisfied as to the validity of the claim and to make an early assessment of liability.[135] This duty encompasses an obligation to comply with any reasonable request by the insurer to furnish specified additional information or to produce specified documents or records.[136] The Act sets out 7 separate matters that are relevant to the assessment of the reasonableness of a request.[137]

The claimant must comply with any request by the insurer to undergo a medical or other health-related examination, a rehabilitation assessment, an assessment to determine attendant care needs or an assessment to determine functional and vocational capacity, by health practitioners or other qualified persons nominated by the insurer.[138] However, the claimant is not obliged to comply if the examination or assessment is unreasonable, unnecessarily repetitious or dangerous.[139]

Additional information-related obligations on injured persons apply to claims for weekly payments, including in relation to medical certificates, periodic certificates of fitness for work, changes of circumstances, and authority granted to the insurer to receive information from treatment and service providers concerning treatment and other services given to the claimant and the claimant's condition or treatment.[140]

Part 4 of the Guidelines sets out detailed provisions governing a wide range of insurer conduct in connection with the handling and resolution of claims. Division 6.2 of the Act sets out general duties of claimants and insurers in relation to claims (for example, a duty to act towards one another with good faith in connection with the claim).

'Full and satisfactory' test

The requirement for a claimant to provide a 'full and satisfactory' explanation for delay or failure to comply with an obligation applies in several provisions of Part 6 of the Act. In both cases, there is a threshold objective requirement for an explanation to be considered 'satisfactory'.[141] In the case of delay, the requirement is that a reasonable person in the claimant's position *would have been justified* experiencing the same delay. In the case of non-compliance with a duty, the requirement is that a reasonable person in the position of the claimant *would have failed* to have complied with the duty. This latter requirement relating to non-compliance with a duty may be considerably more onerous on the claimant than the requirement relating to delay because it omits the word 'justified'. If the requirement relating to non-compliance with a duty were equivalent to the requirement applying to delay, it would be: "*a reasonable person in the position of the claimant would have been justified in failing to comply …*". The Review proposes to consider the practical operation of these tests and whether they could or should be aligned whilst maintaining consistency with Objective (g).

Statutory benefits: dispute resolution

Part 7 of the Act governs dispute resolution. Part 7 of the Guidelines sets out certain time limits and other details for the purposes of Part 7 of the Act.

---

[135] Section 6.24 of the Act.

[136] Section 6.24(2) of the Act.

[137] Section 6.24(3) of the Act.

[138] Section 6.27(1) of the Act.

[139] Ibid.

[140] See sections 3.14 - 3.18 of the Act.

[141] Section 6.2(2) of the Act.

Part 7 of the Act introduces the concepts of **merit review matters**, **medical assessment matters** and **miscellaneous claims assessment matters**. The dispute resolution provisions apply differently, depending on this classification of the subject matter of a dispute. The types of disputes within each category are set out in Schedule 2 to the Act. Miscellaneous claims assessment matters include, among other things, assessment of fault for the purposes of claims for statutory benefits.

Claimants may request an internal review by an insurer of a decision about a matter in any of the above categories.[142] An insurer may decline to conduct an internal review if the request is not made by the claimant within 28 days of receiving the decision in question.[143] Generally, an internal review is a necessary first step in the Scheme's dispute resolution provisions unless the insurer fails to conduct the internal review, fails to notify the claimant of its decision or declines to conduct the review.[144]

Part 7 of the Guidelines sets out detailed provisions governing, among other things:

- the application for internal review and the insurer's response
- the requirements as to qualifications of the reviewer and their independence from the initial decision-making process
- circumstances in which the time to notify the claimant of the decision on the internal review is extended beyond 14 days as provided in section 7.9(4) of the Act.

In 2020, insurers conducted 20 internal reviews per 100 claims on average.[145] Of the 1,737 determined internal reviews, 77% upheld the initial claim decision, 1% overturned the decision in favour of the insurer,[146] and 22% overturned the decision in favour of the claimant.[147] 81.9% of internal reviews were completed within the required timeframe.[148]

Regulation 23 in the Regulations[149] has the effect that lawyers may not charge fees to a claimant or insurer for legal services provided in connection with an application for internal review. A range of restrictions apply to legal assistance in other parts of the dispute resolution framework as well. There are a range of concerns that have been raised by legal stakeholders with the regulation of access to legal advice, and fees for legal and medico-legal services within the Scheme. An independent review into legal support within the Scheme for injured persons is underway, commissioned by SIRA. The aim of that review is to assess whether the current framework for legal support and service provision by practitioners is promoting the objects of the Act.[150]

---

[142] Section 7.9(1) of the Act.

[143] Clause 7.5 of the Guidelines.

[144] Sections 7.11, 7.19 and 7.41 of the Act.

[145] SIRA, *CTP Insurer Claims Experience and Customer Feedback Comparison*, December 2020, page 7.

[146] There were 7 such cases. It is not clear how this occurred given that the Act provides for internal review at the request of the claimant, not the insurer.

[147] SIRA, *CTP Insurer Claims Experience and Customer Feedback Comparison*, December 2020, page 8.

[148] Ibid page 9.

[149] Made under section 8.3(1)(c) of the Act.

[150] SIRA, *Submission to the Law and Justice Review*, November 2020, page 28.

Merit review matters

If a claimant is not satisfied with the outcome of an internal review on a merit review matter, they may apply to the President of the PIC for a merit review, to be conducted by a merit reviewer.[151] A 'merit reviewer' is a person appointed under the *Personal Injury Commission Act 2020* to that position for the purposes of the Act.[152] The merit reviewer is to decide what is the "*correct and preferable*" decision having regard to the facts and the law and may affirm, vary or substitute the decision or require the insurer to reconsider the matter in accordance with directions.[153]

Claimants and insurers alike are bound by the decision of a merit reviewer,[154] but may apply within 28 days to the PIC for review by a review panel on the ground that the decision was "*incorrect in a material respect*".[155] The review panel may confirm the decision or may substitute a new decision, in which case that new decision is binding on the claimant and insurer.[156]

For a range of merit review matters, and for any application for review by a review panel, there are maximum fees for legal services that may be charged by a lawyer giving assistance to a claimant or insurer.[157] For other merit review matters, fees for legal services are not allowed.[158]

Medical assessment matters

A claimant, the relevant insurer or a merit reviewer may refer a dispute about a medical assessment matter to the President of the PIC for assessment, to be dealt with by one or more medical assessors.[159] A 'medical assessor' is a person appointed under the *Personal Injury Commission Act 2020* to that position for the purposes of the Act.[160] Evidence given for the purposes of a medical assessment (or a merit review) about any medical assessment matter is not admissible (and therefore must not be considered) unless it is given by a treating health practitioner of the injured person or a practitioner authorised by SIRA under the Guidelines for the purpose of giving evidence about medical assessment matters.[161]

There are provisions for a merit reviewer to refer a medical assessment matter for the provision of a non-binding opinion by a medical assessor.[162]

---

[151] Section 7.12 of the Act.

[152] Section 1.4(1) (definition of 'merit reviewer') of the Act.

[153] Section 7.13 of the Act.

[154] Section 7.14(3) of the Act.

[155] Section 7.15 of the Act.

[156] Ibid; section 7.14 of the Act.

[157] Clause 1 of Part 1 of Schedule 1 to the Regulations.

[158] Section 8.3(4) of the Act.

[159] Section 7.20 of the Act.

[160] Section 1.4(1) (definition of 'medical assessor') of the Act.

[161] Section 7.52 of the Act; regulation 18 of the Regulations made under section 7.52(4)(b) of the Act. The relevant provisions of the Guidelines are in Part 8.

[162] Section 7.27 of the Act. Circumstances could arise where a merit review matter (e.g. whether the cost of treatment and care is reasonable) requires a determination or opinion on a medical assessment matter (e.g. whether treatment and care provided to an injured person is reasonable and necessary).

The costs of medical assessments are payable by the relevant insurer.[163]

For medical assessment matters that concern the degree of permanent impairment of an injured person, the assessment must be made in accordance with the detailed provisions of Part 6 of the Guidelines.[164] There are provisions for interim assessment of permanent impairment if the medical assessor is not satisfied that the impairment has in fact become permanent.[165]

A medical assessment under the Act is conclusive evidence of any matter certified by the medical assessor, except for an assessment of the degree of impairment of earning capacity of an injured person in which case the matter certified is "*prima facie evidence*" of the matter.[166] However, a court may not substitute its own determination of any medical assessment matter (that is, without any exception for degree of impairment of earning capacity).[167]

A merit reviewer may refer a medical assessment matter for re-assessment at any time.[168] Both the claimant and the insurer may, each on one occasion only, refer a medical assessment matter for re-assessment at any time but only on the grounds of deterioration of the injury or additional relevant information.[169]

The claimant or relevant insurer may apply within 28 days for a review of a medical assessment by a review panel, on the ground that the assessment was incorrect in a material respect.[170] The panel can confirm the certificate of the medical assessor or revoke that certificate and issue a new one.[171]

The Regulations limit the fees that may be charged by a lawyer for legal services provided in connection with a medical assessment.

Miscellaneous claims assessment matters

A claimant or insurer may refer a dispute about a miscellaneous claims assessment matter to the PIC at any time for a binding decision.[172] Subdivision 2 of Division 7.6 of the Act ("*Assessment of claims for damages*") applies to the assessment of the dispute with the modifications set out in the Regulations.[173] Regulation 17 of the Regulations makes several such modifications.

There is no provision for any appeal from the PIC's decision on the assessment.

The Regulations limit the fees that may be charged by a lawyer for legal services provided in connection with miscellaneous claims assessment matters.

---

[163] Section 7.28(1) of the Act.

[164] Section 7.21(1) of the Act.

[165] Section 7.22 of the Act.

[166] Section 7.23(2) of the Act.

[167] Section 7.23(5) of the Act.

[168] Section 7.24(1) of the Act.

[169] Section 7.24(2) of the Act; regulation 13(1) of the Regulations.

[170] Section 7.26(1), (2) of the Act.

[171] Section 7.26(7) of the Act.

[172] Section 7.42 of the Act.

[173] Section 7.42(2) of the Act.

Damages: resolution of claims

Two matters preliminary to the making of a damages claim under the Act are the assessments of 'minor injury' and the degree of permanent impairment of the person.

First, if a person has only 'minor injuries' then they cannot claim damages.[174] This issue would ordinarily be expected to be resolved in connection with the person's statutory benefits claim because it affects the entitlement of a person who is not at fault to statutory benefits after the first 26 weeks following the motor accident concerned.

Second, if a person has a degree of permanent impairment not >10%, then they cannot make a claim for damages until 20 months have passed since the motor accident concerned (and cannot claim damages for non-economic loss[175]).[176] There is no occasion to resolve this issue in connection with a statutory benefits claim. Clauses 4.108 to 4.111 of the Guidelines set out a procedure with which insurers are required to comply upon receipt of a request to concede that an injured person has a degree of permanent impairment >10%, including making available an internal review of the decision on the request.

Submissions to the Law and Justice Review have questioned whether the 20 month waiting period for damages claims where permanent impairment is not >10% is necessary and whether it is contrary to Objective (g).[177] The Review is seeking feedback on the 20 month waiting period, including in response to the specific questions set out earlier in this paper under Objective (b).

Damages are claimed under the Act by submission to the relevant insurer of a signed application form.[178] Such a claim must be made within 3 years of the date of the motor accident concerned,[179] subject to provisions which may allow a later submission.[180] Part 4 of the Act limits the types of loss for which damages may be awarded and the amount of damages that may be awarded in respect of allowable types of loss.

As expeditiously as possible and in any event within 3 months of receipt of the damages claim, the insurer must notify the claimant whether it admits or denies liability for the claim (or state which parts of the claim are admitted and which are denied).[181] Admitting or denying liability in this way means admitting or denying liability on behalf of the owner or driver who is alleged to be liable to pay damages.[182] The Guidelines set out a range of matters that the insurer must address in its notice to the claimant, including providing copies of all information relevant to the decision, whether supportive of the decision or not.[183]

---

[174] Section 4.4 of the Act.

[175] Section 4.11 of the Act.

[176] Section 6.14(1) of the Act.

[177] Law Society of NSW, *Submission to the Law and Justice Review*, 9 November 2020, page 7; Australian Lawyers Alliance, *Submission to the Law and Justice Review*, page 41.

[178] Section 6.15(1) of the Act; clause 4.115 of the Guidelines.

[179] Section 6.14(2) of the Act.

[180] Section 6.14(3) of the Act.

[181] Section 6.20 of the Act.

[182] Under the third-party policy issued by the insurer, the insurer insures the owner of the motor vehicle and any other person who at any time drives the vehicle against liability in respect of the death of or injury to a person caused by the fault of the owner or driver of the vehicle in the use or operation of the vehicle: section 2.3 of the Act.

[183] Clauses 4.118 - 4.119 and 4.121 - 4.122 of the Guidelines.

In the case of a claim in respect of injury (but not death), and unless wholly denying liability, the insurer must make a reasonable offer of settlement to the claimant as soon as practicable.[184] Clause 4.123 of the Guidelines provides that a reasonable offer "*is one that is based on the facts and evidence, and is reflective of the injuries and losses the injured person has suffered as a consequence of the motor vehicle accident*." However, the claim must not be settled unless the claimant is legally represented or the settlement is approved by the PIC.[185] If the degree of permanent impairment of the injured person is not >10%, then a damages claim cannot be settled until at least 2 years after the accident.[186]

The claimant has the same duty of full cooperation with the insurer as applies to a claim for statutory benefits,[187] including the obligation to submit to medical and other examinations.[188] In addition, the claimant must give the insurer all "*relevant particulars*" of the claim as described in section 6.25 of the Act.

The Guidelines set out provisions governing investigations by insurers in relation to a damages claim, including medical and surveillance investigations.[189]

Damages: dispute resolution

Under the common law, decisions on all matters of liability for, and quantification of, a claim for damages are the province of the courts in cases where the parties (claimant and defendant) do not agree. However, the Act and Guidelines set out a range of provisions governing the resolution of disputes arising in claims for damages.

Provided that the claimant and insurer have used their best endeavours to settle a damages claim, either party may refer the claim to the PIC for assessment.[190] The PIC has the function of assessing both the issue of liability for damages and the amount of damages.[191] A claimant is not entitled to commence court proceedings on a claim for damages unless the PIC has either certified that the claim is exempt from assessment under section 7.34 of the Act, or certified an assessment of the claim.[192]

The PIC's assessment of liability in relation to the claim (i.e. the liability of the insurer on behalf of the at-fault owner or driver to pay damages to the injured person) is not binding on the parties to the assessment.[193] However, if the insurer admits liability, then the PIC's assessment of the amount of that liability is binding on the parties if the claimant accepts it within 21 days of the issue by the PIC of its certificate of the assessment.[194]

The provisions described earlier for assessment of 'medical assessment matters' apply to damages claims as well as statutory benefits claims. The PIC itself, in addition to the parties, may refer a medical

---

[184] Section 6.22 of the Act.

[185] Section 6.23(2) of the Act.

[186] Section 6.23(1) of the Act.

[187] Section 6.24 of the Act.

[188] Section 6.27 of the Act.

[189] Clauses 4.134 - 4.148 of the Guidelines.

[190] Section 7.32 of the Act.

[191] Section 7.36(1) of the Act.

[192] Section 6.31(1) of the Act.

[193] Section 7.38(1) of the Act.

[194] Section 7.38(2) of the Act.

assessment matter for assessment by a medical assessor under Division 7.5 of the Act.[195] In the assessment of a claim for damages by the PIC, the medical assessor's certificate is conclusive evidence of the matters certified, except in the case of the degree of impairment of earning capacity in which case the certificate is "*prima facie evidence of*" the matter certified.[196]

Several of the 'merit review matters' that may be submitted for merit review under Division 7.4 of the Act concern matters that are ancillary to questions of liability and quantum in a damages claim. For example, whether a claimant has provided the insurer with all relevant particulars about a damages claim in accordance with section 6.25 of the Act[197] is a 'merit review matter' that may be the subject of a binding decision by a merit reviewer. The PIC itself is the decision-maker for 'miscellaneous claims assessment matters', some of which may relate to a damages claim.[198]

If a damages claim does not settle, and is not resolved by the PIC through an admission of liability by the insurer and acceptance by the claimant of the PIC's assessment of damages, then the claim may be resolved by a court (provided that the PIC has assessed the claim or certified that it is exempt from assessment).

Fact-finding by a court is constrained in relation to medical assessment matters – a court must not substitute its own determination as to a medical assessment matter for that of a medical assessor.[199] The constraint on evidence relating to medical assessment matters referred to earlier also applies to assessment by the PIC and proceedings in a court – evidence about any medical assessment matter is not admissible (and therefore must not be considered) unless it is given by a treating health practitioner of the injured person or a practitioner authorised by SIRA under the Guidelines for the purpose of giving evidence about medical assessment matters (known as an 'Authorised Health Practitioner').[200]

In submissions to the Law and Justice Review, several stakeholders, including lawyers and insurers, have raised concerns with the system of 'Authorised Health Practitioners' under section 7.52 of the Act and Part 8 of the Guidelines and have proposed that it be amended or abolished.[201]

The Regulations specify maximum amounts of fees that may be charged by a lawyer for legal services in relation to proceedings in the PIC or a court in connection with a damages claim.

CTP Assist

The Act requires SIRA to establish an advisory service to assist claimants in connection with their claims for statutory benefits and damages and with the dispute resolution procedures, whether under the Act or the *Personal Injury Commission Act 2020*.[202] The service established and provided by SIRA is known as 'CTP Assist'. One element of this service makes independent legal advice available to claimants within the

---

[195] Section 7.20(1) of the Act.

[196] Section 7.23(2) of the Act.

[197] Failure to provide all relevant particulars can lead to deemed withdrawal of the damages claim: section 6.26 of the Act.

[198] For example, whether a late claim for damages may be made in accordance with section 6.14 of the Act.

[199] Section 7.23(5) of the Act.

[200] Section 7.52 of the Act; regulation 18 of the Regulations made under section 7.52(4)(b) of the Act. The relevant provisions of the Guidelines are in Part 8.

[201] Insurance Council of Australia, *Submission to the Law and Justice Review*, 6 November 2020, page 6; Law Society of NSW, *Submission to the Law and Justice Review*, 9 November 2020, page 11; Australian Lawyers Alliance, *Submission to the Law and Justice Review*, pages 26-29.

[202] Section 7.49 of the Act.

Scheme (in relation to matters where paid legal advice is allowed) over the telephone free of charge to the claimant. This element of CTP Assist is known as the 'CTP Legal Advisory Service'.

Carers NSW considers that CTP Assist, in addition to providing support to injured persons in relation to making a claim, should be "*carer inclusive*" by both recognising and supporting carers who provide support in decision-making.[203]

Insurers as decision-makers in the Scheme

It is a notable feature of the Scheme that insurers are asked to decide whether the facts exist which govern their liability to pay statutory benefits to injured persons, and that if an insurer decides against the injured person then the injured person's recourse is to enter into a dispute with the insurer.

There is an assumption running through the framework for the Scheme that it is necessary for insurers to decide whether an injured person is entitled to receive statutory benefits and, if so, what benefits, in what amount and for how long. One of many examples of this is in section 3.16 of the Act, which provides in relation to weekly payments that an insurer "*can make a decision about the pre-accident earning capacity or post-accident earning capacity of an injured person at any time.*" This is addressed to the calculation of weekly payments. An injured person's entitlement to a particular amount of weekly benefits is not, as a matter of strict entitlement, subject to the insurer's decision about that matter. However, the Scheme contemplates that the insurer will decide the amount it must pay to the claimant and, if the claimant does not agree with the insurer's decision (either initially or on internal review), then the claimant must approach the PIC to lodge a dispute.

Although as a practical matter the Scheme contemplates that insurers will make decisions about their own liability to injured persons to pay statutory benefits, as a general proposition the Act does not in fact give insurers' decisions any legal effect. That is, an injured person's entitlements do not depend on an insurer's decision as to those entitlements. In this respect, an injured person's rights within the Scheme differ from situations where a person's rights can depend on an exercise of decision-making power.

There are examples of such powers in the Act. One such example is SIRA's power to grant a licence to an insurer to issue third-party policies in the Scheme. An insurer has no right to such a licence except insofar as SIRA decides to exercise its decision-making authority to grant the licence.[204]

In relation to a licensing decision, it is a necessary corollary to SIRA's power to grant the licence that an insurer wishing to be licensed must apply to SIRA to make a decision whether to grant the licence. If SIRA refuses to grant the licence and the insurer is not content to accept the decision, then SIRA and the insurer will effectively be in dispute and the Civil and Administrative Tribunal has the authority to adjudicate that dispute.[205]

In contrast, an insurer's liability to pay statutory benefits arises under Part 3 of the Act depending on the existence of certain facts, and not on any decision by the insurer. In short, if a person is injured in a motor accident in NSW then the 'relevant insurer' is liable to pay statutory benefits to that person in accordance with Part 3 of the Act. The insurer's liability is established by the existence of the facts that Part 3 sets out as the facts governing an injured person's entitlements. For example, if the person's injuries are not caused by their own fault, then the 'relevant insurer' will be liable to pay statutory benefits beyond 26 weeks. Even though in practice the insurer is asked to decide whether it is liable, under the terms of Part 3 the insurer's liability does not depend on that decision; it simply depends on the facts.

The source of the insurer's liability to pay statutory benefits is different from its liability to pay damages to an injured person. The insurer's liability to pay damages arises under a contract between the insurer and the

---

[203] Carers NSW, *Submission to the Law and Justice Review*, 16 October 2020, page 2.

[204] Section 9.3(1) of the Act.

[205] Section 9.14(1)(a) of the Act.

owner of the vehicle driven by the at-fault driver (i.e. the insurer's liability is, strictly speaking, a liability to the at-fault owner or driver to indemnify the owner or driver under the CTP policy issued by the insurer to the owner).[206] In a damages claim, the claimant on one side and the insurer, standing in the shoes of the defendant, on the other side are necessarily in an adversarial position in relation to each other. If they can agree on the at-fault owner or driver's liability and the quantification of damages, then they may have no dispute. If they do not agree, then they are in a dispute which must be resolved either by agreement or by a person or tribunal with authority to resolve it.

Statutory benefits claims arguably need not give rise to disputes between claimant and insurer. One of the intentions on the introduction of the Scheme was to "*reduce … the adversarial nature of the scheme*"[207] and, the Review understands, to make the handling of statutory benefits claims inquisitorial in nature at least to some degree. One way in which the Scheme seeks to achieve this is to limit the paid legal assistance available to claimants (although it does not limit an insurer's access to advice from its own in-house legal team). However, arguably the restriction or otherwise of access to legal advice by one or even both parties does not address the adversarial position in which claimant and insurer are placed when the insurer is asked to decide matters of fact on which the two parties have opposing interests. To the extent that the insurer is cast in the role of inquisitor, it is a notable feature of that role that the insurer also has a direct interest in the outcome of the inquiry. The Review proposes to consider whether changes are needed to the Scheme to better secure the objective of quick, cost effective and just resolution of disputes, including whether changes to the Scheme could avoid altogether making adversaries of claimant and insurer in relation to at least some issues that arise in statutory benefits claims.

Questions

General questions

64. Does this objective remain 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?

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

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

Specific questions

In answering the above general questions, interested parties may wish to consider the following specific questions. Interested parties are asked to provide evidence (where available) in support of the answers.

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)?

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

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

---

[206] The contract is on the terms set out in section 2.3 of the Act.

[207] New South Wales, *Second Reading Speech - Motor Accident Injuries Bill 2017 (NSW)*, Legislative Assembly, 9 March 2017.

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

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)?

Internal review

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

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

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

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?

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

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?

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?

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

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

CTP Assist

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

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?

84. If so:

    (a) who would be the decision-maker?

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

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

Objective (h)

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

Legislative framework

Collection of data by SIRA

The legislative framework for Objective (h) insofar as it relates to the collection of data by SIRA and the sharing of data is primarily set out in Division 10.5 of the Act. Division 10.5 provides that SIRA may collect, use and disclose data relating to third-party policies, claims for statutory benefits or for damages, the functions, activities and performance of insurers, and the provision of health, legal and other services to injured persons.[208] SIRA may obtain these data from insurers, relevant insurance or compensation authorities, hospitals, government agencies, and from any other source.[209] Insurers can be required under section 10.24 of the Act to disclose data to SIRA relating to third-party policies, claims "*and other related matters under this Act*", including data relating to any aspect of the Scheme, and policies or claims generally, or particular policies or claims. The information required to be disclosed extends to personal or health information that may otherwise be subject to restrictions on disclosure under the *Privacy and Personal Information Protection Act 1998* or the *Health Records and Information Privacy Act 2002*.

Division 10.5 also authorises information exchange between SIRA, the Lifetime Care and Support Authority and the insurers.[210]

Division 10.5 also provides that SIRA is to maintain a claims register with details of claims notified to insurers and the Nominal Defendant, among other claims that may be relevant to the Scheme. This register is to be accessible only by SIRA, licensed insurers and other SIRA-approved persons and bodies.[211]

Clause 3.28 of the Guidelines provides that, for the purpose of supervision of the Scheme and of insurer performance specifically, insurers must provide "*timely, accurate and complete information*" to SIRA including but not limited to:

- insurer claims manuals, policies and procedure documents, including updates as they occur
- policyholder and claimant information packs
- standard letter templates
- self-audit results, including quality assurance reporting
- complaints received by the insurer about its handling of matters
- policyholder and claimant survey results
- training plans and logs, and/or data breaches that affect the privacy of a policyholder, claimant or their family.

The Guidelines also deal with the provision of information or documents relevant to the payment of statutory benefits to SIRA from the Lifetime Care and Support Authority.[212] Under clause 9.29, the Lifetime Care and

---

[208] Section 10.23(1) of the Act.

[209] Section 10.23(2) of the Act.

[210] Sub-sections (3), (4) of section 10.23 of the Act.

[211] Section 10.25 of the Act.

[212] Under section 3.2(3) of the Act, the Lifetime Care and Support Authority is the 'relevant insurer' in respect of statutory benefits for treatment and care payable more than five years after the motor accident concerned. Under section 3.45(2) of the Act, the Lifetime Care and Support Authority is the 'relevant insurer' in respect of statutory benefits for treatment

Support Authority must comply with SIRA's reasonable requests to provide information or documents relevant to the payment of statutory benefits for treatment and care in relation to a claim.

The Act does not, in express terms, place limits on SIRA's authority to use the data it collects in accordance with the framework to secure Objective (h). Therefore, as a general proposition, SIRA can use the data to carry out its functions under the Act which include, among other things:[213]

- to monitor the operation of the Scheme, and in particular to conduct (or arrange for other persons to conduct) research into and to collect statistics or other information on the level of statutory benefits and damages paid by insurers, the level of damages assessed by the PIC and awarded by the courts, the handling of claims by insurers and other matters relating to the Scheme
- to advise the Minister as to the administration, efficiency and effectiveness of the Scheme
- to publicise and disseminate information concerning the Scheme
- to investigate and respond to complaints about premiums for third-party policies, the market practices of licensed insurers and claims handling practices of insurers
- to monitor compliance by insurers with:
  - (d) the Act and the Guidelines, and
  - (e) the *Personal Injury Commission Act 2020* and the statutory rules under that Act
- to investigate claims to detect and prosecute fraudulent claims
- to issue and keep under review the Guidelines under Division 10.2 of the Act
- to provide an advisory service to assist claimants in connection with claims for statutory benefits and claims for damages, and with dispute resolution under Part 7 of the Act or the *Personal Injury Commission Act 2020*
- to provide funding for:
  - (f) measures for preventing or minimising injuries from motor accidents, and
  - (g) safety education
- in relation to the provision of acute care, treatment, rehabilitation, long term support and other services for persons injured in motor accidents:
  - (h) to monitor those services
  - (i) to provide support and funding for programs that will assist effective injury management
  - (j) to provide support and funding for research and education in connection with those services that will assist effective injury management
  - (k) to develop and support education programs in connection with effective injury management.

Section 11.2 of the Act imposes a strict regime of confidentiality around 'protected information' collected in the exercise of functions under the Act, where 'protected information' is (if not publicly available):

- information concerning the business, commercial, professional or financial affairs of an applicant for a licence under the Act or of a licensed insurer; or

---

and care payable to an injured person if the Authority has entered into an agreement to assume responsibility for payment with the insurer otherwise liable to pay those statutory benefits.

[213] Section 10.1(1) of the Act.

- information obtained in the course of an investigation of an application for such a licence; or
- information that was obtained by SIRA under the Act from a licensed insurer and that is the subject of an unrevoked declaration by the licensed insurer to the effect that the information is confidential; or
- information concerning the business, commercial, professional or financial affairs of the provider of a passenger service or a booking service or the holder of a taxi licence under the *Point to Point Transport (Taxis and Hire Vehicles) Act 2016*.

However, section 11.2 does not affect section 9.15 of the Act, which provides that SIRA may from time to time publish information about compliance by, or pricing, profitability or performance comparisons of, CTP insurers or other information that it is in the public interest to publicise. Section 9.15(4) of the Act qualifies SIRA's power to publicise such information where it relates to an identified insurer in certain circumstances.

Collection of data by insurers

The Act, Regulations and Guidelines generally place few obligations on insurers to collect particular information. However, there are provisions that require claimants to give particular information to the relevant insurer[214] and SIRA has supervisory powers that could address data collection.

Under section 9.5 of the Act, SIRA may impose conditions on the licence of a CTP insurer that are not inconsistent with the Act or the Regulations. Under section 9.6(1), those conditions may, without limitation, be for the purposes of ensuring compliance with obligations or the efficiency of the Scheme generally, or relate to the provision of information concerning claims and profits. SIRA could impose obligations relating to the collection of data to enable SIRA to carry out its functions under the Act on insurers as licence conditions.

Questions

General questions

85. Does this objective remain valid?

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?

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

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

Specific questions

In answering the above general questions, interested parties may wish to consider the following specific question. Interested parties are asked to provide evidence (where available) in support of the answer.

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?

[214] For example, section 6.25 of the Act provides that a claimant for damages must provide the insurer of the person against whom the claim is made with "*all relevant particulars about the claim*", being the information listed in sub-section (2) of section 6.25.

4. SCHEME IMPLEMENTATION: KEY PERFORMANCE INDICATORS

Introduction

Deloitte has developed Key Performance Indicators (KPIs) to assess the extent to which the 2017 Scheme is achieving intended objectives of the Act. We take this opportunity to note that the assessment of success or wellness of schemes such as this are not always reducible to objective metrics. KPIs tend to be quantitative in nature, and not all aspects of the 2017 Scheme are quantifiable in nature. Because of this, Deloitte will complement KPIs with qualitative assessments of a range of information provided by SIRA, based on our observations, experience with other schemes and feedback from this consultation process. Further, Deloitte acknowledges that it may not be possible to quantitatively assess all proposed KPIs due to information limitations. Any such instances may indicate a potential gap in current monitoring and reporting, and Deloitte will use all available information to provide some assessment. Finally, if Deloitte observes material differences in the metric attributable to the same KPI across different information sources, we will include discussion of these in our final report.

The KPI framework presented in this Discussion Paper has been developed by Deloitte based on a preliminary review of available data. Each stated Scheme objective is deconstructed into its component parts and KPIs defined to assess each component. The KPIs are proposed as building blocks for the assessment of each objective and are not to be considered in isolation.

The ultimate aim of this review is to determine whether the policy objectives of the Act remain valid and whether the terms of the Act (and those regulations and guidelines) remain appropriate for securing those objectives. The scope of the review also includes recommending any further changes to the CTP scheme to meet the objectives, and outlining any risks and issues raised during the stakeholder consultation and mitigation strategies to address those.

Rick Shaw
Partner
Deloitte Touche Tohmatsu

Proposed KPI Framework

This section provides the proposed KPIs that will be used to assess the effectiveness of the implementation of the objectives of the 2017 Scheme. There is a separate section for each Scheme objective.

Once the KPIs are finalised, a metric will be assessed for each KPI, and Deloitte will assign a 'Red, Amber, or Green' status to each KPI.

- Red: Indicator of areas for improvement and/or potential Scheme changes required.
- Amber: There may be areas for improvement, or it may be too early to assess the current level of experience.
- Green: The Scheme is meeting its objectives through the lens of that particular KPI.

The metric assigned to each KPI will be assessed at an aggregate Scheme level, rather than at an individual insurer level, given the assessment is intended and scoped to be at an aggregate level. Further, all KPIs will be assessed as at 31 December 2020 (using data as at 31 March 2021), which aligns to the triennial review of the 2017 Scheme. Some metrics may be reported as at other dates depending on information availability. Scheme experience beyond 31 March 2021 may be considered, however will not be the focus of Deloitte's assessment. Deloitte may consider some KPIs at an individual insurer, accident year or injury severity level depending on information availability and whether in our view this improves the assessment of the extent to which the 2017 Scheme is meeting its objectives.

An aggregated assessment across all the KPIs will then be conducted to form a view on each of the eight (8) Scheme objectives.

For seven (7) of the eight (8) objectives of the 2017 Scheme, we are seeking stakeholder feedback on the following three (3) questions. This means 21 items of feedback (7 objectives by 3 questions):

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 for selecting the two (2) KPIs.

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.

Discussion

The KPI Framework separates objective (a) into three (3) components based on the terms 'early', 'appropriate' and 'maximise their return to work or other activities'.

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

To assess how the CTP scheme has encouraged *early* treatment and care of claimants, we have focussed on claim acceptance rates and timeliness of claim events including report of claim, liability decisions, treatment, and payments.

KPI TITLE	KPI DESCRIPTION
CLAIM ACCEPTANCE RATES	The rate of statutory benefits claims accepted by insurers.
TIMELINESS OF CLAIM REPORTS	Percentage of claims reported within 28 days after the accident date.
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.
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.
TREATMENT AFTER A CLAIM IS MADE	Average number of days from claim lodgement to treatment approval date and/or first accessing treatment.
TIMELINESS OF RECOVERY PLANS	Percentage of recovery plans completed within 12 weeks of claim lodgement.
TIMELINESS OF PAYMENTS	Percentage of claims with an interval between date of receipt of invoice and medical benefit paid less than 20 days.

Qualitatively, we will consider the level and effectiveness of actions taken to increase public awareness (such as advertisements and campaigns) and accessibility of CTP scheme benefits to assess the 'encourage' element of the objective. This includes consideration of how more vulnerable people are supported and their claim reporting patterns, and may include the following groups;

- Those who speak a Language other than English (LOTE);
- Aboriginal and Torres Strait Islander people;
- Lower socio-economic groups; and
- People with physical or other impairments.

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

To assess how the CTP scheme has encouraged *appropriate* treatment and care of claimants to achieve optimum recovery, we have focussed on medical professional involvement at the initial triage stage and the extent to which claimants transition between injury severity levels; claim declinature rates beyond the 26-week period; and statistics based on qualitative feedback including complaints and customer satisfaction metrics. The scope of this review does not include assessment of individual claim files, which would provide a more specific assessment of the appropriateness of treatment and care provided. We are aware that such reviews have been conducted by other organisations since Scheme inception, the results of which may be considered in our analysis.

KPI TITLE	KPI DESCRIPTION
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).
DECLINATURES POST 26 WEEKS	Percentage of claimants declined cover after being on benefits for 26 weeks.
COMPLAINT VOLUMES	Percentage of complaints per Green Slip referred to SIRA's supervision teams.
CUSTOMER SATISFACTION	CTP Assist Net Promoter Score (NPS) and customer effort scores.

Qualitative factors considered for this objective to be indicative of appropriate treatment include self-reported:

1. general health scores,
2. pain scores, and
3. mental health.

The volume of claims that transition severity level and the reasons why they transition will also be examined. Some claims will naturally transition as the severity of the claim increases, however, some may have been misidentified as a minor injury claim.

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

The final component of objective (a) is to maximise claimants return to work (RTW) or other activities. SIRA regularly monitor several RTW and stay at work metrics. The *SIRA regulatory measurement of customer experience and outcomes study* commissioned of the Social Research Centre (SRC report) further examined claimants return to other 'everyday life' activities. We note that a SIRA review of the CTP Scheme RTW measures that is currently in progress as at 1 April 2021 may impact this object in the future.

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

Objective (b)

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

Discussion

The KPI Framework separates objective (b) into two (2) components based on the terms 'early' and 'ongoing'.

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

KPI To assess how the CTP scheme has provided *early* financial support to claimants, we have focussed on claim acceptance rates regardless of fault, and timeliness of claim events including recovery plans and payments. The assessment will also consider sufficiency of payment levels as a percentage of pre-accident weekly earnings (PAWE).

KPI TITLE	KPI DESCRIPTION
CLAIM ACCEPTANCE RATES	The rate of statutory benefits claims accepted by insurers. (Duplicated from KPIs in objective (a))
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))
TIMELINESS OF INCOME SUPPORT PAYMENTS	Percentage of claims with time between date of lodgement and first income support benefit less than 13 weeks.
INCOME BENEFIT TIMELINESS DISPUTES	Proportion of disputes related to timeliness of income benefit payments.
PAYMENT LEVELS	Verification of income support payments as a percentage of PAWE in line with the legislation.

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

The proposed KPIs to assess how the CTP scheme has provided *ongoing* financial support to claimants consider the appropriateness of the duration, timeliness, and level of financial support.

KPI TITLE	KPI DESCRIPTION
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).
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).

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.
INCOME BENEFIT COMPLAINTS	Volume of complaints related to income benefit payments.
INCOME BENEFIT AMOUNT DISPUTES	Proportion of disputes related to amount of income benefit payments.
INCOME BENEFIT TERMINATION DISPUTES	Proportion of disputes related to termination of income benefit payments.

Objective (c)

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

Discussion

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. However, it is noted that every year there is a volume of claims associated with unregistered hence uninsured vehicles.

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.

Discussion

The KPI Framework separates objective (d) into two (2) components based on the terms 'profits achieved by insurers do not exceed the amount that is sufficient to underwrite the relevant risk' and 'limiting benefits payable for minor injuries'.

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

The CTP scheme aims to achieve affordability through various means including managing insurers profits margins within a 3-10% range and the use of profit mechanisms including the Risk Equalisation Mechanism (REM) and the Transitional Excess Profit or Loss (TEPL) mechanism. Whilst the KPIs described below focus on premium makeup and profit margins, broader discussions on this object may include review of the application of the REM and the TEPL to the extent it has been possible to assess based on claim development to date, and the actual versus expected claims experience since 2017 Scheme inception.

KPI TITLE	KPI DESCRIPTION
PREMIUM AFFORDABILITY	Ratio of premium to the AWE.
PREMIUM MAKEUP	Claims 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.

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

Prior to the 2017 Scheme inception, premiums were rising (SIRA, 2018, p. 5)[1]. This was driven by minor injury experience factors:

1. Increased frequency of claims for minor injuries.
2. Higher proportion of the cost of minor injury claims spent on legal and investigation costs.
3. Increase in fraudulent claims.

This object addresses the first two (2) factors listed above and the third factor is assessed in objective (f). The KPIs for this object consider minor injury claims from the lens of benefits paid, duration of claims, transition to non-minor injury severity, and the level of legal involvement and costs. The SIRA review of the minor injury definition will be a key input into the review of this object.

[1] SIRA. (July, 2018). *NSW Motor Accidents CTP scheme. Scheme performance report 2017.* New South Wales Government, SIRA. https://www.sira.nsw.gov.au/__data/assets/pdf_file/0008/314819/CTP-scheme-performance-report-2017.pdf

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

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.

Discussion

The 2017 Scheme aims to address competitiveness in the NSW CTP insurance market and barriers to new entrants, including a high risk of being adversely selected against. Premiums had been increasing for several years raising affordability issues for policyholders and the question of sustainability for the Scheme as a whole. The 2017 Act aimed to address these concerns through the terms of objective (e), which the KPI Framework separates into three (3) components: 'competition', 'innovation', 'sustainability and affordability'.

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

To assess *competition* in the setting of premiums for third-party policies, we consider KPIs focused on the individual insurers market share and profit margins. Qualitatively we will consider any adverse impacts on competition arising from the application of the REM.

KPI TITLE	KPI DESCRIPTION
CHANGES IN MARKET SHARE	Percentage change in market share year on year for each insurer.
MARKET PLAYERS	Retention of licensed insurers and addition of new entrants e.g. Youi.

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

To assess *innovation* in the setting of premiums for third-party policies, we will consider qualitative questions of how SIRA has created opportunities for innovation and how they have recognised the innovation of individual insurers.

KPI TITLE	KPI DESCRIPTION
OPPORTUNITY FOR INNOVATION	Opportunities created for innovation. For example, changes in the point to point (P2P) space, and taxi and hire car industries.
RECOGNITION OF INNOVATION	Recognition of innovation. For example, via TEPL or Innovation Support.

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.

The CTP Scheme is *sustainable* if all stakeholders are benefitting, that is, if premiums are *affordable*, insurers are making sufficient profits, and claimants are receiving timely and appropriate benefits. The assessment of this second part of the object 'to provide the Authority with a role to ensure the sustainability and affordability of the compulsory third-party insurance scheme and fair market practices' is dependent on the assessment of the other objects.

KPI TITLE	KPI DESCRIPTION
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.
SUSTAINABLE FOR INSURERS	Insurer profit margins on the average premium since 2017 Scheme inception. (Duplicated from KPIs in objective (d))
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))

Objective (f)

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

Discussion

CTP related fraud encompasses fraud perpetrated by claimants, vehicle owners and service providers including medical or health professionals, legal professionals, and the automotive sales and repairs professionals. It can manifest as hard fraud such as false or misleading information and staged motor accidents, or soft fraud such as the overstatement of legitimate claims.

Deloitte will qualitatively consider the roles and responsibilities, monitoring and reporting, initiatives such as dissemination of monitoring insights to the public, as well as recovery efforts and penalties, across all stakeholders in the CTP system. Both a preventative and detective lens will be applied in respect of fraud deterrence. SIRA are currently undertaking a procurement process to develop predictive analytics to detect systemic fraud in the system, which is an example of an initiative to inform preventative measures against fraudulent activity.

The following KPIs assist in assessing the success of fraud deterrence in the CTP system, from both a detective and preventative lens.

KPI TITLE	KPI DESCRIPTION
FRAUD INVESTIGATIONS	Volume of investigations as a percentage of total claim volumes.
FRAUD PROSECUTIONS	Volume of prosecutions annually and compared to volume of open claims.
FRAUD RECOVERY RATES	Fraud recovery rates annually expressed as amount recovered in proportion to premiums.
COMPARISON AGAINST HOSPITAL DATA	Ratio of CTP claims that eventuate compared to the number of road accident victims that attend hospital.
PREVENTATIVE MEASURES	Programs in place to prevent fraud from occurring.

Objective (g)

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

Discussion

The KPI Framework separates objective (g) into four (4) components based on the terms 'early', 'quick', 'cost effective' and 'just'.

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

A review of the *early* resolution of motor accident claims necessarily considers claims durations, the time from lodgement to closure. Our review will also consider the volume of reopened and reactivated claims in comparison to new, active, and closed claim volumes to gauge the appropriateness of claim closures.

KPI TITLE	KPI DESCRIPTION
AVERAGE CLAIM DURATIONS	Average claim durations (days) from lodgement to closure, separately considering statutory and common law claims.
TIMELINESS INTERNAL REVIEW DECISIONS	Percentage of claims with time between date of complaint and date of resolution for internal disputes less than 28 days.

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

To assess SIRA's encouragement of the quick resolution of disputes we will consider the timeliness of the dispute resolution processes. More broadly, consideration of this KPI will review the trend in the number of matters litigated year on year, as this may increase as more common law claims emerge. We note that the Personal Injury Commission (PIC) took over matters from the Dispute Resolution Service (DRS) as at 1 March 2021, however the cut-off for our assessment is 31 December 2020. Hence our review will focus on the DRS and insurers internal reviews rather than limited PIC experience.

KPI TITLE	KPI DESCRIPTION
TIMELINESS INTERNAL REVIEW DECISIONS	Percentage of claims with time between date of complaint and date of resolution for internal disputes less than 28 days. (Duplicated from KPIs in objective (g.1))

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

To assess the cost-effective resolution of disputes the KPI framework examines various costs associated with the handling, escalation, and settlement of disputes.

KPI TITLE	KPI DESCRIPTION
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).
COST OF SETTLEMENTS	Costs of settlement for claims with disputes compared to claims without disputes.
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.

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

The KPIs for the just resolution of disputes reflect the fairness and reasonableness of dispute outcomes for both the claimant and the insurer.

KPI TITLE	KPI DESCRIPTION
INTERNAL REVIEW OUTCOMES	Percentage of insurer internal reviews determined in favour of claimant.
OVERTURNED DISPUTES	Percentage of disputes heard by SIRA's Dispute Resolution Services (DRS) that are overturned.
OVERTURNED LITIGATIONS	Percentage of litigated claims overturned.
COMPLAINTS ABOUT DISPUTES	Percentage of finalised disputes that subsequently make a complaint.

Objective (h)

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

Discussion

The implementation of the 2017 Act introduced the Universal Claims Database (UCD) which contains information on all claims in the CTP scheme provided by the individual licensed insurers. SIRA regulates and supervises the data collected and validates the quality of the data. Insurers have direct access to the UCD to monitor their own performance. The UCD is also used to support the CTP Open Data tool which is publicly accessible online and enables stakeholders to compare insurers.

The proposed KPIs evaluate the effective management of CTP data and the Open Data tool. More broadly, the review will consider any gaps in usage and monitoring of the available data, as well as the incidence of loss, misuse, or cyber related, data collection and use risks.

KPI TITLE	KPI DESCRIPTION
OPEN DATA TOOL	Usage rates of the online Open Data analysis tool.
DATA QUALITY	Error rates in the data submitted to the UCD by individual insurers.

APPENDIX A: QUESTIONS FOR STAKEHOLDERS

Objective (a)

1. Does this objective remain 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?
3. What is the evidence that the Scheme is, or is not, achieving this objective?
4. What changes (if any) should be made for the Act, Regulations and Guidelines to secure, or better secure, this objective?
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?
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?
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?
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?

Minor injury

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

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?
12. Having regard to the Objectives of the Act, why should they be limited, or why not?
13. If they should be limited, what should be the nature and extent of the limits?
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?

Objective (b)

15. Does this objective remain 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?

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

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

Weekly payments

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

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?

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?

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)?

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?

Minor injury

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

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

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?

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

28. Does the 20 month period:

    (a) encourage early resolution of claims?

    (b) deter injured persons from making damages claims?

    (c) effectively deter fraud?

29. Does the 20 month period benefit:

    (a) injured persons;

    (b) insurers; or

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

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%?

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

Objective (c)

32. Does this objective remain valid?

33. 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?

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

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

Objective (d)

36. Does this objective remain valid?

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?

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

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

40. Objective (d) identifies two means of keeping premiums affordable – regulating insurer profits and limiting benefits for minor injuries.

    (a) Should this objective be expanded to include other means of keeping premiums affordable?

    (b) If so, what other means should be considered and why?

41. Does 8% exceed, or not exceed, the amount of profit that is sufficient to underwrite the relevant risk?

42. Are any aspects of the TEPL mechanism not expected (when activated) to secure the objective of keeping premiums affordable by regulating insurer profits?

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?

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 to the Act?

Objective (e)

45. Does this objective remain 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?

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

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

Competition on premium

49. To what extent do CTP insurers compete on premium in the NSW market?

50. How can the framework in the Act, Regulations and Guidelines better promote competition on premium in the NSW market?

Innovation in premium setting

51. What innovations in premium setting would benefit the Scheme?

52. Does the framework in the Act, Regulations or Guidelines need to change to allow or encourage those innovations?

Point to point industry

53. Are there commercial disparities (particularly for small business operators) in the point to point industry?

54. If so:

    (a) to what extent will the current reforms to determination of CTP premiums for taxis and hire vehicles address them?

    (b) are there innovations in premium setting that could further address them?

SIRA's role in relation to sustainability, affordability and fair market practices

55. Is the framework which defines SIRA's role in relation to sustainability, affordability and fair market practices adequate and appropriate to enable SIRA to take steps to ensure that these aims are achieved?

Objective (f)

56. Does this objective remain valid?

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?

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

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

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:

    (a) the 'minor injury' framework?

    (b) the penalties for fraud?

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

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

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

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?

Objective (g)

64. Does this objective remain 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?

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

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

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)?

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

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

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

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)?

Internal review

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

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

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

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?

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

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?

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?

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

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

CTP Assist

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

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?

84. If so:

    (a) who would be the decision-maker?

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

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

Objective (h)

85. Does this objective remain valid?

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?

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

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

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?

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 for selecting the two (2) KPIs.

APPENDIX B: GLOSSARY OF TERMS

Term	Description
1999 Scheme	Previous NSW CTP insurance scheme, based on the Motor Accidents Compensation Act 1999
Act	Motor Accident Injuries Act 2017
CTP	Compulsory third-party (a common term for the type of insurance that is mandatory under the Act)
Guidelines	Motor Accident Guidelines (Version 7 Effective from 1 March 2021)
Indexation Order	Motor Accident Injuries (Indexation) Order 2018
KPI	Key performance indicator
Law and Justice Review	SCLJ's '2020 Review of the Compulsory Third Party Insurance Scheme'
Lifetime Care and Support Authority	The Lifetime Care and Support Authority of New South Wales constituted by the Motor Accidents (Lifetime Care and Support) Act 2006
Minister	Minister for Customer Service
NSW	New South Wales
Objectives	The objects of the Act set out in section 1.3(2) of the Act
PIC	Personal Injury Commission, established under the Personal Injury Commission Act 2020
Regulations	Motor Accident Injuries Regulation 2017
REM	Risk equalisation mechanism
Review	The review required by section 11.13 of the Motor Accident Injuries Act 2017 and being carried out by Clayton Utz and Deloitte
Scheme	The scheme of compulsory third-party insurance and provision of benefits and support relating to the death of or injury to persons as a consequence of motor accidents established by the Motor Accident Injuries Act 2017
SCLJ	The Standing Committee on Law and Justice of the NSW Parliament

SIRA	State Insurance Regulatory Authority
TEPL Guidelines	Motor Accident Guidelines - Transitional Excess Profits and Transitional Excess Losses (30 September 2019)
Third-party policy	A policy of CTP insurance issued under the Act

Sydney
Level 15
1 Bligh Street
Sydney NSW 2000
+61 2 9353 4000

Melbourne
Level 18
333 Collins Street
Melbourne VIC 3000
+61 3 9286 6000

Brisbane
Level 28
Riparian Plaza
71 Eagle Street
Brisbane QLD 4000
+61 7 3292 7000

Perth
Level 27
QV.1 Building
250 St Georges Terrace
Perth WA 6000
+61 8 9426 8000

Canberra
Level 10
NewActon Nishi
2 Phillip Law Street
Canberra ACT 2601
+61 2 6279 4000

Darwin
17–19 Lindsay Street
Darwin NT 0800
+61 8 8943 2555

www.claytonutz.com