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COMPLIANCE AND PERFORMANCE REVIEW OF THE NSW WORKERS COMPENSATION NOMINAL INSURER

NSW Business Chamber

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OVERVIEW

The NSW Business Chamber (the Chamber) welcomes the opportunity to provide a submission to the Compliance and Performance Review of the Workers Compensation Nominal Insurer, icare.

The Chamber is one of Australia's largest business support groups, with a direct membership of more than 20,000 businesses, providing services to over 30,000 businesses each year. Tracing its heritage back to the Sydney Chamber of Commerce, established in 1825, the Chamber works with thousands of businesses ranging in size from owner operators to large corporations, and spanning all industry sectors from product-based manufacturers to service provider enterprises.

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TABLE OF CONTENTS

INTRODUCTION

With a membership that overwhelmingly consists of employing businesses, that is businesses required to take out workers compensation, the Chamber takes an active role in discussion and debate on workers compensation and workplace health and safety (WHS) regulations. Accordingly, the Chamber welcomes the opportunity to provide a submission to the *Compliance and Performance Review of the Workers Compensation Nominal Insurer*.

The Chamber is a committed advocate for a workers compensation scheme and WHS regulatory framework that is both sustainable and fair over the longer term.

The Chamber recognises the need to support injured workers and the benefit, wherever practical, of allowing this recovery to occur at work. It needs to be emphasised, however, that support for injured workers needs to be appropriately balanced against maintaining the long term sustainability of the scheme.

At a scheme wide level it is fair to say that many employers have benefited from recent reforms to the scheme. However, feedback received by the Chamber and commentary across business identifies challenges in respect to the distribution and availability of information and strong concerns in respect to claims management practices. These issues, if left unaddressed, threaten to impact the future sustainability and affordability of the system.

The Chamber supports return to work as a key metric for the calculation of premium loadings, however, the system needs to be better calibrated to mitigate factors that fall outside an employer's control in delivering successful return to work outcomes, such as administrative failure by claims agents and access to medical resources on.

A consistent request made by employers is the need for more information on how the workers compensation system operates and additional guidance on how to obtain more information in respect to the calculation of premiums and real time updates on claims management.

Both feedback received by the Chamber, and the Chamber's own experiences engaging with the nominal insurer, suggests the lack of transparency within the system needs to be addressed as a priority. To build confidence in the system, employers need more effective mechanisms for engagement delivered through additional transparency and independent support from the State Insurance Regulatory Authority (SIRA) is needed as well as improvements in claims management.

Included in **Appendix A** are declassified examples some of our members have provided in regard to their experience(s) with the nominal insurer and the workers compensation system generally. We continue to receive feedback from members on their experiences and will share these with the review team where agreed to by our members. The Chamber is happy to help facilitate further discussions with these affected businesses if requested.

PART A. ISSUES WITH THE NEW STRUCTURE

The new structure (being the split of WorkCover NSW into three entities) was created by the *State Insurance and Care Governance Act 2015*. The purpose of the legislation was described in the second reading speech[1] in the following terms:

"*The new structure will be far more transparent and accountable and, most importantly, lead to better outcomes for injured workers. The new organisations will be more customer-centric, streamlined and efficient, building economies of scale and focusing on clear objectives. . .*

The Government is committed to a workers compensation system that is fair, financially sound and focused on earlier recovery and return to work for those injured workers who have the capacity to do so. A system that is fair, sustainable and customer-centric will provide the best protection for workers, employers, the community and our economy."

The NSW workers compensation system is a compulsory insurance scheme funded by employers who bear ultimate financial responsibility for any scheme deficit. SIRA advises that icare issues 74% of total premiums with its agents EML, Allianz and GIO managing 65% of total active claims. It is understood that the Nominal Insurer operates without needing to comply with APRA's minimum capital requirements and transparency.

UNDERSTANDING AND NAVIGATING THE SYSTEM

Feedback from our members suggests information currently available about the NSW workers compensation system is either overly simplistic or too voluminous and/or not fit for purpose.

The Chamber is aware of a number of instances where businesses have been given incorrect advice or, when seeking advice, being referred between agencies with each passing accountability for information to the other.

It should be remembered that for the vast majority of businesses, a workplace injury that results in time off work, is a relatively rare occurrence. This combined with the numerous pieces of legislation and substantial reforms to workplace health and safety, workers compensation and workplace injury management and rehabilitation, many employers may have a limited understanding or awareness of how to navigate their statutory obligations.

As primary customers and, ultimately, funders of the scheme, helping employers navigate the system effectively needs to be further emphasised in an assessment of the performance of SIRA, icare and its scheme agents.

To address concerns regarding the availability of information and to improve confidence in the system, the Chamber recommends the establishment of dedicated client support 'help

[1] Mr Dominic Perrottet (Hawkesbury – Minister for Finance, Services and Property) 5 August 2015, https://www.parliament.nsw.gov.au/bills/Pages/bill-details.aspx?pk=316

line' within SIRA. This service would assist employers through the provision of advice as well as provide timely feedback to SIRA on the experiences of business in engaging with the nominal insurer and its agents. A focus of this service might include employers who are experiencing their first claim in the last three (3) years as such employers are likely to have a lower level of understanding of their obligations than employers who deal with the system more regularly.

Employers are also concerned about the lack of opportunity to challenge decisions being made within the system, other than by way of internal review. The creation of a new, independent review process to address these concerns would be a useful addition.

Injury Prevention and Return to Work

The Chamber is concerned that despite the separation of the three agencies (icare, SIRA and SafeWork NSW) there remains significant and unnecessary overlap within functions. This is creating confusion for both employees and employers on obligations and responsibilities.

Under the 2015 re-structure, it was clearly emphasised that injury prevention would be the primary remit of SafeWork NSW. Despite this, SafeWork NSW inspectors are now also acting as return to work agents for SIRA. Feedback from employers suggests this is creating an unnecessary level of conflict between the regulator and employers as the reasonable practicality of an injured worker's return to a workplace is being primarily determined by safety inspectors who are charged and trained to issue licences and registration for potentially dangerous work and investigate workplace incidents (not assess whether or not it is reasonably practicable for an injured worker to return to a particular workplace). The Chamber believes that both the functions and responsibilities as defined above should be clearly separated and specifically that SafeWork NSW be excluded from acting as return to work agents.

Technical Knowledge of Auditors

From member feedback, the Chamber understands that staff engaged by the providers of audit services used within the scheme to monitor compliance with the legislation, have on occasion, lacked the requisite skills and experience required to make correct determinations.

One example concerns an auditor who was not familiar with the statutory definition of 'apprentice' (despite the relevant section being referred to in the workers compensation legislation) and incorrectly determined that the employer was not entitled to an apprentice rebate despite having employed an apprentice.

A second example is where the auditor incorrectly determined that the directors' loan was wages because he failed to properly interrogate the accounts and did not realise that the amounts were repayments of the original loan of [redacted] (which the directors had already paid

tax on after having sold all of their personal assets to keep the business afloat) as opposed to being remuneration (where sums are 'lent' to directors). In this particular case, the directors kept timesheets but had not drawn down any wages (which were being accrued on the books) because they felt the business could not afford to pay them.

There is a significant amount of trust placed in the technical knowledge of auditors and some employers would probably simply accept the auditor's assessment, not knowing it was incorrect. The Chamber is concerned the instances we are aware of are symptomatic of a much broader problem.

PART B. ISSUES WITH THE NEW PREMIUM SETTING MODEL

Over the past few years, the Market Practice and Premium Guidelines have been amended following consultation in the latter part of the calendar year. Insurers have been required to submit their filings for the following premium year by the end of February, with changes in premium (effective from 1 July) not being advertised until close to the end of the financial year.

LACK OF TRANSPARENCY

The premium formula is no longer published. While the formula was complex, employers could at least review the formula and engage independent third parties to conduct individual assessments. The 2015 changes introduced the 'file-and-write' system where each year's formula remains confidential.

The formula has changed over time and, due to the confidentiality surrounding the 'file-and-write' system, there is no way for an employer to find out how and why the premium formula changed and understand how aspects of their business, such as labour on-costs, are likely to be affected.

Requests made by the Chamber to secure additional information regarding the premium formula or the scheme in general, have been refused by icare as the information is classified as being 'commercial in confidence'. The Chamber does not understand how such information could be classified commercial in confidence as there are no competitors to the nominal insurer for the statutory scheme.

In a competitive market it would be possible for employers to compare alternative providers and select the best or preferred arrangement. However, given the nominal insurer's role as a monopoly provider there are no alternative options available.

The Use of WIC Codes to Measure An Employer's Risk Profile

A significant component of the premium formula is the workers compensation industry classification system (commonly known as the 'WIC Codes'). The WIC code is used to calculate the 'Basic Tariff Premium' and is supposed to reflect the risks inherent in a particular industry sector.

WIC codes adopt the industry codes published by the Australian Bureau of Statistics, known as the Australian and New Zealand Standard Industrial Classification (ANZSIC). The current edition is dated 2006 and was last revised in March 2016.

Up Until the 2018-19 Premium Year

The 'file-and-write' system requirements are contained in SIRA's *Market Practice and Premium Guidelines*.

Up until the 2018-19 premium year, the WIC Codes adopted ANSZIC 1993. This meant that the risk profile of new and emerging industries could not be recognised, let alone measured.

Since the 2018-19 Premium Year

The premium filing for the 2018-19 premium year reduced the number of WIC codes being used across the scheme. 392 pages of WIC codes (Appendix A to the Market Practice and Premium Guidelines – For premium filings on or after 1 March 2018') was reduced to 12 pages of 'pooled' WIC codes.

It is difficult to see how the risk profile of a particular industry or employer can be adequately measured and monitored with such a blunt instrument.

The Chamber is concerned with the apparent lack of consultation surrounding such a significant change and the conflicting explanations given for why this reform approach was pursued. We propose that to meet the policy principle of being 'fair and reflective of risk', the use of the entire suite of (the most recent version of) ANSZIC codes should be reintroduced.

Volatility

The major contributor to the level of volatility and expense being experienced by employers appears to be the way in which the Claims Performance Adjustment (CPA) is calculated.

The CPA is a loading charged to larger employers (known as experience-rated employers) in addition to the Basic Tariff Premium, purportedly to 'strike a reasonable balance' between risk pooling and individual employer experience.

It is calculated by reference to the length of time an employer's injured worker is in receipt of weekly benefits and uses this figure as a starting point to work out the multiplier to be used to calculate the loading.

As was stated at the outset of this submission, while the Chamber supports return to work being utilised as a key metric in determining premiums, return to work is not completely within an employer's control (with other factors such as claims management and the availability of medical support also impacting). Beyond this, while it is appropriate that signals within the calculation of premiums incentivises early and sustainable return to work, the Chamber maintains there is a real risk that, if not changed, the current application of multipliers and loadings on premiums could lead to perverse outcomes.

The multiplier currently being used results in an unnecessary level of volatility, especially for particular industries, such as transport and care providers. The most extreme example encountered by the Chamber concerned a recently formed company which was part of a group where $773 of claims costs translated into $6,108.53 of additional loading (almost half of the Basic Tariff Premium).

For example, in the 2018-19 premium year the upper limit of the range of applicable multipliers was increased from a **loading of 250%** of BTP to a **loading of 498.5%** of BTP.

To date, the Chamber has not been able to secure an explanation as to:

- how these multipliers were determined;
- why a particular value is attributed to a particular cohort of employer;
- why there is such a broad range; and
- the justification behind extending the highest loading from a loading of 250% of BTP to one of 498.5% of BTP.

This level of volatility is causing significant cash flow issues for businesses, especially those in regional areas.

Premium Paperwork

The current timetable for the file and write system for setting premiums is unfairly prejudicial for experience-rated employers, creating significant cash-flow problems and threatening the viability of businesses. This is especially the case for those regionally based business that are already dealing with the impact of extreme weather and drought.

In addition to a tight time-frame for approving and then publishing the premium formula for the following premium year, employers are reporting protracted delays in receiving premium notices and claims history reports, with some containing errors and omissions.

While the Chamber played an active role in supporting these members by obtaining extensions of time for the payment of premiums (without penalty), premium notices should be able to be finalised and administered without the intervention from a third party representative.

Debt Collection Activity

While debt collection is a necessary part of the system and helps ensure that all employers are contributing to the scheme, businesses have reported debt collection activities by icare in circumstances when no debt was in fact due. This has created an understandable level of stress, confusion and concern for the businesses affected and is a clear example of poor practice. Clearly, in undertaking debt collection more care needs to be taken to ensure that a debt is actually owed.

PART C. ISSUES WITH CLAIMS MANAGEMENT

The New Claims Management Model

The Design of the Model

Prior to the introduction of the new claims management model implemented by icare, larger employers had the benefit of being able to communicate with a single claims manager.

For many businesses this translated into more efficient return to work outcomes for those employers, as the dedicated scheme agent was familiar with the employer's business operations and return to work systems.

For many employers, the new claims management model has led to a noticeable deterioration in return to work outcomes. The Chamber has received advice from a business that their number of open claims has doubled on account of administrative delays.

For some experience-rated employers, the inefficiencies arising from the design of the model have not only contributed to suboptimal return to work outcomes, but have contributed to an escalation in premiums.

Whether the Model is 'Customer-Centric'

Some members have commented that the new model appears to have prioritised the injured worker and excluded the employer.

For example, some employers are reporting that, despite being able to provide 'suitable duties', injured workers are being permitted to refuse to return to work, despite having the capacity to do so.

The Transition From Scheme Agents to 'Claims Agents'

By deciding to bring the management of claims 'in-house', icare is said to have determined that it would no longer need all 5 scheme agents operating within the system. Instead, it would gradually reduce the number of agents to 3 and then to 1 (being EML).

One reason cited for this change is the use of different computer systems by the various scheme agents and the need to have all agents using the same system.

The reduction from 5 agents to 3 was to occur in preparation for a 1 January 2017 start. In February 2016, CGU (being one of the original 5) announced it would not apply for a claims agent contract. In April 2016, icare announced that QBE's application had been unsuccessful.

In preparation for the 1 January 2017 start date, all agents were required to 'clean' their files so they could be loaded into the new system.

Throughout this period, a number of businesses reported to the Chamber that claim files were being left dormant while staff (particularly from CGU and QBE staff) went on extended periods of leave. As a consequence, it appears these businessess have experienced increases in their premiums for reasons beyond their control.

Claims Management Practices

Employers are reporting their concerns with current claims management practices, including:

- Certificates of Currency being accepted despite being incomplete/out of date/forward-dated/unsigned (by the worker) certificates of currency.
- A failure to consult or communicate with employers adequately or at all when determining the circumstances of the injury; whether the employer can offer 'suitable duties'; or whether an injured worker is in breach of their medical restrictions or are working elsewhere.
- Staff being inexperienced or poorly trained.
- The decline in referrals to rehabilitation providers.
- Issuing liability decisions that do not adequately reference the legislative requirements and/or evidence taken into consideration.

Although problems with claims management practices existed prior to the 2015 amendments, the new structure and models have exacerbated those issues which, in turn, have contributed to the issues with unfair, unaffordable and volatile premiums.

PART D RECOMMENDATIONS

THE NEW STRUCTURE

1. Establish a dedicated service 'help line' within SIRA for employers of injured workers to seek advice and assistance in understanding and navigating the system.

2. Establish an independent review mechanism for employers.

3. Provide a clearer delineation between the roles and functions of the three agencies so a greater focus can be given to improving return to work outcomes.

4. That SafeWork NSW be excluded from acting as return to work agents.

4. SIRA to conduct routine assessment and/or audits to ensure return to work inspectors possess the relevant skill set for determining whether or not an injured worker's return to work is reasonably practicable from an employer's perspective.

5. Introduce a continuing professional education program for all auditors (whether engaged by SIRA or icare) to complete prior to conducting any audit activity.

THE PREMIUM SETTING MODEL

6. Prescribe the content of premium notices (including a detailed explanation of how the formula operates and, if there has been a change since the previous premium year, of how and why it has changed) by regulation (after having conducted stakeholder consultation).

7. The formula be published in full.

8. To meet the policy principle of being 'fair and reflective of risk', reintroduce the use of the entire suite of (the most recent version of) ANSZIC codes.

9. Introduce further measures to avoid the current level of volatility within the system.

10. Establish a set timetable so employers are afforded at least 3 months' notice of any change to their premium and increase transparency throughout the year in relation to how the formula is likely to change and how current claims costs are likely to impact an experience-rated employer's future premium.

11. Amend the insurer standards document so it includes customer service standards and benchmarks relating to response times for telephone calls, correspondence, and requests for information.

12. Conduct an audit of the nominal insurer's internal systems to assess the incidence of errors and omissions in respect to claims management and associated administration.

13. Amend the insurer standards document so it includes customer service standards and benchmarks relating to debt collection activities.

THE CLAIMS MANAGEMENT MODEL

14. Establish and publish mandatory disclosure requirements (both form and content) for all decision-making activities that are required by the legislation (for example, liability decisions).

15. Re-introduce an account management feature into the model.

16. Create realistic and measurable key performance indicators for successful return to work outcomes against which the performance of the nominal insurer (and its agents), employers and employees can be measured and reported to SIRA, with EML having a second line of reporting to SIRA (as well as to icare).

17. Amend the insurer standards document so it includes stricter customer service standards and benchmarks relating to claims management practices and procedures.

APPENDIX A

EXAMPLE 1

I am writing to let you know we had significant problems with Icare due to overbilling and with injury management ie an employee was on workers compensation for 7 months for a simple fracture, where he should have been back to work within 10 weeks. As a result we now are paying a consultant $6000.00 p.a. to monitor our workers compensation calculations for premiums and claims.

It took us several weeks of constant fighting with Icare to resolve the over charging, and they have never accepted fault in regard to the fracture claim even though we had evidence to prove it. We complained to several MP's including the Treasurer who agreed to a meeting. Just before the meeting was due to take place he "fobbed us off" to his Senior policy advisor. This meeting was a waste of time, as even though he was surprised and very concerned about the issues we raised but he did nothing about it. He promised the Treasurer would be notified of our concerns and the General Manager of Icare and The Treasurer would respond to our issues. We have had no response from either person despite several emails being sent to the policy advisor. The meeting took place earlier in March 2019.

EXAMPLE 2

My husband and I have a business that requires us to have Workers Comp insurance. I received an invoice from Icare regarding my payment details for the year in advance, but I never received one from when I had lodged my Declaration of Actual Wages. I kept getting letters telling me my payment was overdue so I sent an email to Icare to say I hadn't received an invoice and it took them two months to reply to me and I still never got the invoice I wanted.

We lodge a lot of Declaration of Actual Wages for our clients and so many of them have received letters from Icare telling them they haven't lodged certain years when we have copies in our files.

I personally feel that it was a mistake Icare taking over all the workers comp policies so they need to either get their act together or put on more staff to cover the workload.

EXAMPLE 3

The structural change has in my own opinion been a disaster.

My constant experiences is the service levels of policy processing in adjustment and renewal process, and debtors management is a disgrace, thankfully they were somewhat wise to issue advance certificates of currency, online policy issuance. As a broker unlike majority of our competitors, we actively engage for clients in the policy management and claims advocacy. I am constantly frustrated with the dialogue of whether we are correct broker to the policy

despite sending in letters of authority. Access to information is non-existent whereas previous to iCare basic info level was available by specific fund managers.

Thankfully the call centre is adequately staffed, however the policy management section is clearly not.

Ideal solutions are to bring back 3-4 fund managers that allow the businesses to decide upon quality of service or option of change. This current model is nothing short of a monopoly on single line service.

EXAMPLE 4

We have had a recent workers compensation claim for a psychological injury dealing with Icare. I have found them extremely difficult to work with and their communication has been non-existent. The claim that was lodged by our employee was accepted provisionally and they had 12 weeks to ascertain whether they were going to accept full liability. It was investigated and the report submitted well within the 12 weeks however, our claims manager didn't seem to prioritise finalising it and when I last spoke to her she advised me that "she still had 3 weeks" till the 12 week period was up before she made a decision on liability.

Early in the claim I asked her was she referring him to an IME and she said she would make that decision once the investigation was complete. I found this unusual as most claims that I have been involved with it is the first thing they do as part of the process.

She has only just referred him to an IME with the 12 week period ending on 7th June. This is all premium impacting on our policy and they don't seem to really be concerned with this. Her responses took days before she would return my calls and she was very condescending in her reply's and tone when speaking with me.

I have been involved with other forms of Workers Compensation Insurers and in particular NSW Local Government insurer Statecover and I never had issues like this with them. The case manager would be in contact with me all the time and we were always consulted over whether to accept liability or not. We would scheduled meetings with the lawyers and discuss the case, the investigation results and the Drs report and make a decision then. We have not been afforded this type of consultation with Icare and we are not treated like we are the client.

I also advised her that the claimant was continuing to behave in a way that was exacerbating his condition and that she needed to deal with the claim as a matter of priority but again she didn't seem to care.