STATUTORY REVIEW OF THE MOTOR ACCIDENT INJURIES ACT 2017

Report

CLAYTON UTZ

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1. INTRODUCTION

1.1 Background

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

The Scheme is set out in the Act, the regulations made under the Act (**Regulations**),[1] and the Motor Accident Guidelines (**Guidelines**) issued by the State Insurance Regulatory Authority (**SIRA**) under the Act.

An important element of the Act was to require the Minister to review the Act, the Regulations and Guidelines against the policy objectives of the Act and report to Parliament after the first 3 years of the new Scheme (**Review**). The terms of reference for the Review are set out in section 11.13 of the Act (and reproduced in Part 2 of this report).

Clayton Utz and Deloitte Touche Tohmatsu Pty Ltd (**Deloitte**) were commissioned by SIRA to undertake the Review on behalf of the Minister for Digital, Minister for Customer Service. Clayton Utz focused on whether the design and terms of the Act, Regulations and Guidelines meet the policy objectives of the Scheme, while Deloitte focussed on the implementation of the Act with reference to specific 'key performance indicators' (**KPIs**). We published a Discussion Paper which summarised the framework of the Scheme and posed a number of questions. In response to the Discussion Paper, we received written submissions from 17 separate stakeholders and conducted 13 formal consultation meetings.[2] This report sets out our findings and recommendations.

1.2 Policy objectives of the Act

The policy objectives of the Act appear in section 1.3(2) of the Act itself. They are reproduced below, with a descriptor 'Objective (a)' through to 'Objective (h)' which we have created for the purposes of the Review (and which correspond with s 1.3(2)(a) to s 1.3(2)(h) of the Act).

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.

[1] *Motor Accident Injuries Regulation 2017*.

[2] Written submissions and formal consultation meetings are listed at the end of Part 3 of this report.

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 the Objectives are intended to manifest including, among other things:

- the provision of statutory benefits to provide income replacement ('weekly payments') and to pay for treatment and care;
- frameworks to limit the benefits available to persons with 'minor injuries' only and persons whose injuries result from an accident caused 'wholly or mostly' by their own fault;
- restricted access to lump-sum compensation for loss;
- a regime for internal review of insurer decisions and external resolution of disputes;
- a framework to limit access to legal advice and representation;
- mechanisms to regulate premiums for CTP policies, distribute premium income among insurers and regulate insurer profits directly; and
- an extensive role within the Scheme for the regulator, SIRA.

The insurance contemplated by the Scheme is provided by insurers who are licensed by SIRA. Another of SIRA's roles is to issue the Guidelines, a form of delegated legislation in the Scheme which sets out the detail of some of the obligations on injured persons who have claims in the Scheme, and on insurers as they manage those claims and in the conduct of their CTP business generally. Compliance with the Guidelines is a condition of each insurer's licence.[3]

Where statutory benefits for treatment and care are needed by an injured person beyond five years after the motor accident concerned, the 'relevant insurer' liable to pay the statutory benefits becomes the Lifetime Care and Support Authority (**LTCSA**) and ceases to be the licensed insurer initially liable on the claim. In some circumstances, an insurer and LTCSA may agree to transition an injured person's claim to the management of LTCSA before five years have passed. In such a case the injured person's treatment and care continues to be funded by the insurer for the full five years but LTCSA manages the claim.

1.3 Structure of this report

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. This is necessary to consider whether the Objective remains valid and whether the terms of the Act, Regulations and Guidelines (that is, the framework of the Scheme) remain appropriate to secure the Objective. To fulfil the terms of reference it is also necessary to measure the implementation of the Scheme against the Objectives through the use of appropriate metrics, both quantitative and qualitative.

Part 1 of this report – this Introduction – sets out some of the considerations and overarching issues that have guided our analysis of the framework for the Scheme and the feedback we received after publication of our Discussion Paper. It includes Recommendation 1 for amendment of the Act to require future reviews.

Part 2 reproduces the Review's terms of reference.

[3] Section 10.7 of the Act.

Part 3 sets out:

- our Recommendations 2 to 33 relating to each Objective and a discussion to explain those recommendations; and
- our discussion and Recommendations 34 to 49 relating to certain matters that, while concerned with the achievement of the Objectives, are not well suited to discussion under only one of them.

Part 4 presents the results of Deloitte's analysis of the implementation of the Scheme and includes their recommendations derived from that analysis.

Part 5 is a collated list of all Recommendations.

Part 6 is a glossary of terms used in the report.

Appendix A to the report summarises the stakeholder feedback to the Review and **Appendix B** is a copy of the Discussion Paper to which stakeholders responded.

In discussing the Objectives and making our Recommendations, we do not repeat in Part 3 of this Report all of the summary of the Scheme in the Discussion Paper or the summary of stakeholder feedback in Appendix A. The discussion and Recommendations are nevertheless informed by our assessment of the Scheme and the feedback as described in those summaries.

1.4 Considerations guiding the Review

1.4.1 Executive summary

We have been guided by some overarching considerations which we summarise below and then describe in some detail. They arise from our analysis of the framework as well as stakeholder feedback, and provide an important backdrop to our analysis of the Objectives.

- The framework for the Scheme must be considered against the Objectives of the Act with due regard for the complex balance between the benefits available to injured persons, ease of access to benefits, affordability of CTP insurance, and validity of claims.
- The Act is not designed with the purpose of compensating injured persons in full for their loss, but principally to support them with treatment and care and financially. There are some guiding principles that flow from that proposition.
- The statutory benefits regime in the Scheme is intended to be non-adversarial. It is not designed to achieve that in a structural sense, but instead to regulate claims management conduct. We observe that the nature of insurers' liabilities in the Scheme is such that, at a point, the interests of injured persons who make claims and insurers who seek to make profits are not always aligned. This is relevant to the regulation of claims management conduct.
- Measurement of implementation of the Scheme is important to guide analysis of the framework. However, summary statistics of Scheme performance that can be assessed positively do not prevent analysis of potential improvements, and it is important that data and analysis about the Scheme is reviewed critically.

1.4.2 Benefits & ease of access / validity of claims & affordability

The Objectives of the Act are inevitably, to some degree, in a state of competitive tension and the legislation must strike a balance in pursuit of them. This is particularly acute in relation to four aspects of the Scheme, two of which are important to persons who have been injured and the people who depend on them, and two that are of importance to the motoring public generally – the vast majority of whom will not need to obtain benefits from the Scheme. The Scheme must balance the benefits available to injured persons and the ease of access to those benefits, with affordability of CTP premiums and the need to ensure the validity of claims under the Scheme. Most of the Objectives of the Act affect each of these aspects of the Scheme.

It is ultimately a matter for the Parliament to strike this balance. The Review makes recommendations which are intended to assist in that process, with the benefit of the first 3 years of experience with the Scheme. In

making these recommendations we are guided by the proposition that the Scheme cannot achieve its Objectives if it does not provide for adequate health-related and financial support to injured persons, and if the process required to access that support undermines the support itself. We have kept in our minds the need for injured persons to validate their claims. We have also kept in mind that the Scheme is not designed to provide full compensation to injured persons, and that the clear intention of the Act is to limit the cohort of injured persons who can access lump-sum compensation, and that this is as an aspect of the Scheme designed to improve affordability of CTP insurance and limit the opportunity for making claims that are dishonest or exaggerated.

Where we have recommended changes that would increase the benefits available to injured persons, there will likely be a role for the Scheme Actuary to comment on the effect of the changes to CTP premiums. It is relevant to observe that, as Deloitte has found, the Scheme is achieving 'affordability' very well in comparison to the CTP scheme based on the *Motor Accidents Compensation Act 1999* (**1999 Scheme**) that it replaced. Accordingly there may be room to improve the availability of benefits without affecting achievement of the Objective to keep CTP premiums affordable. It is also relevant to observe that, on current projections, the level of insurer profit in the Scheme is such that there may be some room to improve the availability of certain benefits without affecting CTP premiums at all. These observations are important because, in our view, some changes are needed to the Scheme in order to achieve the fundamental objective of providing for adequate health-related and financial support to injured persons (Objectives (a) and (b) in section 1.3(2) of the Act).

1.4.3 Compensation to injured persons

The Scheme provides compensation to injured persons through a framework of benefits and entitlement to claim damages, but the Scheme is generally not designed to 'compensate' injured persons fully. There may be few injured persons whose entitlements are governed by the Act who will have access to full compensation for loss associated with injuries resulting from a motor accident, including if the accident was caused by the fault of another person and caused serious injuries.[4]

Some stakeholders consider that the Act should be amended to include compensating injured persons as one of its objectives. We do not agree. Such an objective would be inconsistent with the framework for the Scheme as set out in the Act. However, there are several propositions that flow from the absence of a compensation objective and the fact that, generally, injured persons' entitlements within the Scheme may not fully compensate them for their loss. They include the following:

1. The design of the Scheme should enable injured persons to receive the health-related and financial support that they need.
2. It is incumbent on those who administer the provision of benefits in the Scheme – the insurers – to ensure that injured persons receive all of the benefits to which they are entitled. The Scheme's framework needs to support insurers to do this. This is the least that can be expected by injured persons and others who depend on them for support, and the public generally.
3. It is incumbent on SIRA – as the Government agency charged with advising the Minister as to the administration, efficiency and effectiveness of the Scheme[5] – to keep each of points (1) and (2) above under review, as well as more generally to keep under review the complex balance between the benefits available, ease of access to those benefits, affordability of CTP premiums, and validity of claims.
4. Finally, the Scheme is not a 'social safety net'. It is not the intention of the Act that the Scheme should provide a minimum necessary amount of support, and otherwise rely on injured persons to self-fund the loss resulting from their injuries if they can afford to do so. Rather, subject to specific limitations that are part of the design of the Scheme, and although the Act is not intended to compensate all injured persons fully, the Scheme aims to provide the treatment and care that

[4] Section 1.3(3)(b) of the Act.

[5] Section 10.1(1)(b) of the Act.

injured persons reasonably need to maximise their return to work and other activities, and to provide financial support that is adequate for injured persons.

1.4.4 A non-adversarial Scheme

It is said that the statutory benefits aspect of the Scheme is intended to be non-adversarial, or less adversarial than the framework to claim damages.[6] An adversarial claimant experience is said to have the potential to induce stress and worsen health outcomes.[7]

When the Scheme was in its design stage, the CTP Reference Panel tasked with consulting on the details of the Scheme envisaged a "cultural shift to a less adversarial scheme model"[8] and noted that, before the introduction of the Scheme, there was an "adverse culture developing in claims management on the part of some insurers".[9] It was recognised at that time that a "strong regulatory framework is critical to encouraging a significant cultural shift from the current adversarial regime."[10]

It is important to understand what is meant by saying that the statutory benefits aspect of the Scheme is (or should be) non-adversarial. The Scheme could be non-adversarial in a structural sense, to remove the potential for the non-alignment of the interests of claimant and insurer to affect the handling of claims. Alternatively, the Scheme could be non-adversarial in the sense that the injured person and insurer, whatever their respective interests, conduct themselves in such a way that they simply co-operate to ensure that the injured person receives the benefits to which they are entitled.

We assume that all participants in the Scheme should be aligned in wanting to achieve the right treatment and health outcomes for those who suffer injury. However, in relation to a claim for statutory benefits (as in the case of a claim for damages), the financial interests of the injured person and the insurer are not necessarily aligned; they are in conflict for as long as insurers who participate in the Scheme do so to make a profit. This conflict can be heightened in respect of certain decisions such as whether the person's injuries are 'minor injuries' because for persons who have only 'minor injuries', statutory benefits entitlements are reduced and they will not be able to succeed in a claim for lump-sum damages.[11] However, it is also the case in respect of a multitude of decisions that the Scheme requires in the course of a claim, including decisions about income support and the treatment and care for which benefits are payable.

The potential for conflict between the interests of injured persons and insurers is recognised by several stakeholders. When it was raised in the hearings for the Parliament of New South Wales Standing Committee on Law and Justice's (**Law and Justice Committee**) 2020 Review of the Compulsory Third Party Insurance Scheme (**Law and Justice Review**), the Insurance Council of Australia (**ICA**) responded:[12]

> *I think from a statutory benefits point of view, our interest is in helping the person to recover quickly because at the end of the day that means it costs us less money in the longer term. So I think it is unfair to say that we are sitting here reluctant to hand over the money. We are interested in getting people better.*

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[6] See, for example: New South Wales, *Second Reading Speech - Motor Accident Injuries Bill 2017 (NSW)*, Legislative Assembly, 9 March 2017; SIRA, *Minor Injury Review*, page 2; Law and Justice Review, *Hearing Transcript*, 25 May 2021, pages 30-31 (Ms Isley); page 38 (Mr Concannon).

[7] SIRA, *Minor Injury Review*, pages 9, 26.

[8] CTP Reference Panel, *CTP reform consultation observations*, September 2016, page 3.

[9] Ibid, page 12.

[10] Ibid, page 19.

[11] Section 4.4 of the Act.

[12] Law and Justice Review, *Hearing Transcript*, 25 May 2021, page 31 (Ms Isley).

This response recognised that the insurers have a financial interest in the outcome of a statutory benefits claim, and asserted that their interest aligns with those of the injured person. The response was only addressed to decisions about reasonable and necessary treatment and care, and not to other decisions that insurers are required to make. However, even in relation to treatment and care, there may not always be complete alignment between the interests of an insurer who is asked to pay for treatment and care, and those of the injured person. We recognise that insurers price the premiums for CTP insurance for the purpose of paying a certain amount in claims. They will pay many claims promptly, willingly and in the best interests of injured persons. The pricing will include an element of profit. An insurer must appropriately and prudently manage its business profitably. That is in the interests of the Scheme. However, from an institutional point of view, insurers have an interest in keeping claims costs at or below the level for which they allow in their pricing. This has the potential indirectly to affect the way that some claims are handled, and the result may not always be in the best interests of the injured person.

The issue of conflict was raised in our Discussion Paper.[13] In subsequent consultation meetings, the ICA put forward the proposition that, because of the profit adjustment mechanism under the Act ('TEPL'), the insurer has no financial interest in the outcome of a claim because self-interested management of a claim is not a way to maximise profit; profit has a maximum of 10%. Therefore, the interests of claimant and insurer are not in conflict.

We respectfully disagree. If and when fully activated, TEPL will reduce the notional industry average profit margin to 10%[14] but it will not set each insurer's profit margin to that level. If insurer A is able to achieve a higher profit margin than insurer B, then after adjustment of profit under TEPL insurer A's profit margin will still be higher than that of insurer B. Some insurers will inevitably retain profit at a level higher than 10%. Under TEPL, it is in an insurer's interests to maximise profit relative to other insurers.

We therefore conclude that an insurer's financial interest in a statutory benefits claim can conflict with the injured person's interests. The Scheme should have a framework that deals with this. Understanding it is relevant to understanding how the Scheme is supposed to be 'non-adversarial'.

1.4.5 A non-adversarial structure

The Scheme could be non-adversarial in a structural sense by taking decision-making out of the hands of either of the parties to a claim. If claims were managed by a disinterested, independent body then the Scheme would be non-adversarial in this sense. The independent body would receive, manage, make necessary inquiries and make decisions on the claim, and the insurer would simply fund the injured person's benefits.

A statutory benefits scheme where claims for treatment and care are managed by a person without a financial interest in the decision-making is in fact already in operation in the form of CTP Care, the service provided in the Scheme by LTCSA. Under section 3.45(2) of the Act, LTCSA and the 'relevant insurer' for a claim may agree to the early transfer of the management of an injured person's claim for treatment and care to LTCSA (i.e. before 5 years have passed and LTCSA necessarily becomes the 'relevant insurer'). In such cases, LTCSA manages the claim for treatment and care and it is funded by the insurer.[15]

If all statutory benefits claims were lodged with a disinterested, independent body, there would be no need for the injured person to interact with the insurer and no need for the body managing the claim to receive input about the claim from the insurer. The insurer would simply be required to pay benefits in accordance

[13] Discussion Paper, page 39.

[14] 'Notional' because the TEPL assessment of profit proceeds on the basis of certain assumptions about expenses and reinsurance. Further, the discussion here ignores 'Innovation Support' which is a percentage of the premium collected by an insurer which, in relation to an approved 'innovation', the insurer may be allowed to keep in addition to the remaining profit after adjustment under TEPL.

[15] Section 3.45(3) of the Act.

with the claim manager's determination of the injured person's entitlements. Information about the claim would be provided to the insurer by the independent body so that the insurer could make an assessment of the expected cost of the claim and manage its finances accordingly.

A design such as this would be non-adversarial in a structural sense and would remove the need to manage the position in which insurers are currently required to make decisions, where their interests are not always aligned with the claimant. Nevertheless, we are not recommending such a fundamental change to the design of the Scheme. It could remain as a realistic option for reform of certain parts of the Scheme if the current Scheme ultimately does not fully achieve the "cultural shift to a less adversarial scheme model".

In this report we make several recommendations to accommodate the existing Scheme design which gives insurers a decision-making role. In our view, it should be possible to manage the conflict and achieve a 'less adversarial' Scheme that gives injured persons their entitlements. We discuss this under the next heading.

1.4.6 A framework for non-adversarial conduct

The Scheme aims to avoid adversarial claim-related behaviour. We understand that this is sought to be achieved by limiting claimants' access to legal advice (on the supposition that claimant lawyers may conduct themselves in an adversarial way, or induce adversarial conduct by insurers) and placing insurers under general obligations to:

- comply with a duty to act towards the claimant with good faith in connection with a claim (which duty encompasses certain specific duties set out in section 6.3(3) of the Act);[16]
- plan steps to be taken "to maintain or, if necessary, create an institutional culture directed to", among other things, "prioritisation of customer service and outcomes";[17] and
- deal with claims in a manner consistent with certain principles including, among others, to "proactively support the claimant to optimise their recovery and return to work and other activities", "make decisions justly and expeditiously", and "communicate with the claimant and keep them informed of the progress of their claim".[18]

In our view, there is scope to enhance the framework in the Act to achieve the aim of non-adversarial claims conduct which sees claimants making validated claims and insurers assisting all claimants to access their entitlements.

Several of the recommendations we make, while they address specific issues that have emerged in the Scheme and require amendments to the framework, should be understood as intended to support insurers in the non-adversarial management of statutory benefits claims. It is essential that the legislation provide this support.

1.4.7 Implementation of the Scheme

Our review of the framework for the Scheme was informed by feedback from stakeholders on the framework itself and its implementation. It was also informed by analysis of the implementation of the Scheme undertaken by Deloitte. As part of their work, Deloitte developed a set of KPIs to measure implementation. These KPIs could also be used after conclusion of this review to assist SIRA to monitor the Scheme and provide assistance to future reviews of the framework.

We recognise the importance of a balanced consideration of quantitative metrics designed to measure Scheme implementation. In SIRA's reports on matters relating to implementation and in Deloitte's

[16] Section 6.3(1) of the Act.

[17] Clause 3.12(a) of the Guidelines.

[18] Clauses 4.5 and 4.6 of the Guidelines.

assessment of KPIs, a positive assessment on a particular metric does not necessarily mean that no changes are needed to the framework relevant to that metric.

For example, in SIRA's 2020 *Review of Minor Injury Definition in the NSW CTP Scheme* (**Minor Injury Review**) it was stated, in relation to persons with minor injuries only and whose income support therefore ceased at 26 weeks:[19]

> *For the people working before the motor accident, data indicated that 70% had returned to work by 13 weeks and 76% had returned to work by 26 weeks. These are positive results but SIRA notes that the quality of insurer data needs to improve, including data that relates to return to work.*

These are indeed positive results from the point of view of the majority of claimants. On the other hand, the assessment means that for 24% of earners, income support stopped before they returned to work. That could be considered a not insignificant percentage of claimants who had not returned to work but stopped receiving support. It seems likely that, in some of those cases, there was the potential for significant hardship.

In the July 2020 *Review of the first 1000 claims in the new 2017 CTP Scheme: Final report*, it was observed that:[20]

> *Time off work beyond 26 weeks post-crash was infrequent among claimants with minor injury, which suggests that the majority of minor injury claimants experience adequate recovery.*

While it is a positive result that the majority of claimants with minor injuries experience adequate recovery, it is also a result that warrants hard work on the design and implementation of the Scheme to achieve a better outcome.

The same review found that:[21]

> *About 1 in 7 claims involved a dispute regarding minor injury determination, of which 20% had the decision overturned. This suggests that although the majority of claims are initially assigned an appropriate minor injury determination, the severity of injury may be underestimated for a small proportion of claimants.*

While this could also be assessed as a positive result, the financial and health consequences for an injured person whose injury was incorrectly assessed could be severe, and a higher benchmark is needed than merely the majority of claims being initially assigned an appropriate classification. The stress and delay to a claimant of having to dispute an incorrect decision can be harmful to the injured person's well-being. This is an outcome that the statutory benefits framework is intended to avoid. There is room for the Scheme to improve the advancement of the Objectives of the Act.

It is incumbent on those who draw conclusions about the current design and implementation of the Scheme to bring a critical eye to the task.

1.5 Future reviews of the Act, Regulations and Guidelines

Before the introduction of the Scheme, the CTP Reference Panel wrote that there would need to be proactive, ongoing reviews of the Scheme to make reforms and improvements on a regular basis as required.[22] The CTP Reference Panel anticipated that there would be "*routine, ongoing scheme review and*

[19] SIRA, *Minor Injury Review*, page 2.

[20] Australian Institute of Health Innovation, *Review of the first 1000 claims in the new 2017 CTP Scheme: Final Report*, July 2020, page 19.

[21] Ibid.

[22] CTP Reference Panel, *CTP reform consultation observations*, September 2016.

update".[23] Essentially it was recognised that, to effect the 2017 reforms, Parliament would have to make a decision on numerous design issues where there were legitimate differences of opinion among stakeholders on the best way forward and where the outcome of some design decisions could not be known with certainty.

The Scheme is currently at a stage where a range of important issues associated with its framework are apparent and should be addressed. However, the operation of some aspects of the Scheme has not yet been fully tested, or tested at all. The Scheme is critically important to the users of roads in New South Wales and is in its early stage of maturing. It should remain under review to make sure that it is working to achieve the objectives of the Act. We consider that periodic, independent reviews of the Act, Regulations and Guidelines are an important element in the ongoing review of the Scheme.

For these reasons, we recommend that the Act be amended to provide for future, periodic reviews at intervals of not more than 5 years.

The current Review commenced in May 2021. Our report was due to be delivered to SIRA 4 months later in September 2021, in accordance with a tight timeline which included a short period for stakeholder consultation.

The short timeline did not allow time to consider in detail all of the issues raised by stakeholders, nor any opportunity to consult on proposals for amendments to the Act, Regulations or Guidelines. Future reviews would benefit from a less compressed timeline. In our view they should be conducted over a minimum of 9 months from commencement until submission of the final report.

Recommendation 1

The legislature consider amending the Act to require the Minister to review the Act (and the regulations and guidelines under the Act), on terms similar to the current section 11.13(1), as soon as practicable after the period of 8 years from commencement of the Act and every 5 years thereafter.

***Rationale**: The Scheme is critically important to the users of roads in New South Wales and is in its early stage of maturing. The operation of some aspects of the Scheme has not yet been fully tested, or tested at all. The Scheme should remain under review to make sure that it is working to achieve the objectives of the Act.*

1.6 Contributors to the Review

In undertaking the Review we had the benefit of feedback on the Scheme from thirty-one different organisations or individuals, including: three individual injured persons, an association of persons affected by the loss of a loved one as the result of a motor accident, the ICA on behalf of each of five licensed insurers in the Scheme (and represented in the consultation meetings by personnel from each of those five insurers), one individual insurer, a law firm, a plaintiff solicitor, the Injury Compensation Committee of the Law Society of NSW and individual members of the committee, the Australian Lawyers Alliance (**ALA**), a medical practitioner engaged in general practice, fifteen medical or allied health organisations, an association of 'road safety professionals and members of the public who are focused on saving lives and serious injuries on our roads', a motorcyclists' association, a research economist, the Independent Review Office (**IRO**), and the LTCSA. We conducted multiple consultation meetings. We also received correspondence from SIRA asking us to consider certain issues relating to the Scheme, and we met separately with the Scheme Actuary and with SIRA's Premium Committee formed under section 10.3(2) of the Act. SIRA provided documents, information, data and technical support, for which we are grateful.

The feedback on the Scheme that we received was uniformly thoughtful, considered and forthright, and therefore valuable to our work. Much of the feedback was provided by persons who invested their personal

[23] Ibid, page 6.

time to facilitate the success of the Review and thus provided feedback effectively in a 'pro bono' capacity. We take this opportunity to express our gratitude to all who contributed.[24]

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[24] The authors also acknowledge with thanks the valuable support in preparing this report from Georgina Riley, Graduate at Law.

2. TERMS OF REFERENCE

Section 11.13 of the *Motor Accident Injuries Act 2017* requires the Minister for Customer Service to review the Act, the *Motor Accident Injuries Regulation 2017*, and the Motor Accident Guidelines and other guidelines issued by SIRA under the Act.

The purpose of the statutory review is to determine whether the policy objectives of the Act, as set out in section 1.3 remain valid, and whether the terms of the Act, Regulation and Guidelines remain appropriate for securing those objectives.

The statutory review is required to start as soon as practicable after the period of three years from the commencement of the Act, with a report on the outcome of the review to be tabled in each House of Parliament within 12 months after that date. As the Act commenced on 1 December 2017, the report must be tabled in Parliament before 1 December 2021.

Section 11.13 of the Act is in the following terms:

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.

The objectives of the Act are set out in section 1.3(2):

(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.
(b)	To provide early and ongoing financial support for persons injured in motor accidents.
(c)	To continue to make third-party bodily insurance compulsory for all owners of motor vehicles registered in New South Wales.
(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.
(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.

(f)	To deter fraud in connection with compulsory third-party insurance.
(g)	To encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes.
(h)	To ensure the collection and use of data to facilitate the effective management of the compulsory third-party insurance scheme.

3. SCHEME DESIGN

3.1 Objective (a) – Treatment and care

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.

Note: Some recommendations under this objective relate to matters in addition to treatment and care, for example weekly payments or claim handling generally.

3.1.1 Introduction

Statutory benefits are payable by the 'relevant insurer' in respect of injuries to persons that result from motor accidents in New South Wales.[25]

Injured persons are entitled to statutory benefits for expenses incurred in connection with providing treatment and care ('treatment and care expenses').[26] 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).[27]

However, statutory benefits are not payable to the extent that the treatment and care is not "reasonable and necessary in the circumstances".[28] This qualification to the relevant insurer's liability is of central significance to the treatment and care aspect of the Scheme. It means that the insurer will not pay for treatment and care unless it agrees with the recommendation of the treating practitioner. Subject to the dispute resolution framework in the Scheme, this can indirectly have the effect of taking authority to make treatment and care decisions out of the hands of the injured person and their treating practitioner, and placing it in the hands of the insurer whose decision as to whether it will pay for treatment and care can be determinative as to whether the injured person receives it, and receives it in a timely way.

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.[29]

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.

In Section 1 of this report, we discussed the need to for the Scheme's framework to support insurers to manage claims in the interests of injured persons. This is critical in the provision of early and appropriate treatment and care.

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

[26] Section 3.24 of the Act.

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

[28] Section 3.24(2) of the Act.

[29] Section 3.26 of the Act.

Feedback to the Review[30] indicates that a proportion of injured persons experience barriers to early and appropriate treatment and care. One of the most important points to emerge from the feedback is that, while dispute resolution mechanisms are important, they are no substitute for unimpeded access to appropriate treatment and care based on the recommendation of treating practitioners. The stress and delay resulting from the need to dispute insurer decisions, and from any interference in treatment and care decisions by insurers' representatives, can produce poor outcomes and hinder the provision of early and appropriate treatment and care.

There are finite resources in the Scheme and it is important that there is oversight of expenditure on treatment and care within the Scheme. In particular, insurers will be concerned to ensure that injured persons do not exaggerate or invent their need for treatment and care, and that insurers do not pay for deliberate or complacent 'over-servicing' by treating practitioners. We are concerned that expenditure on treatment and care has appropriate oversight, but not to the detriment of injured persons and their legitimate claims.

We do not have the evidence before us to show the extent to which injured persons exaggerate or invent their need for treatment and care, or to which treating practitioners over-service patients who are in the Scheme. That is not to suggest that these things do not happen. We assume that insurers and SIRA can and do work together to address issues such as these when they arise. However the burden of solutions to these issues should not, unless it is unavoidable, be visited upon the general population of injured persons. There is, as with many aspects of the Scheme, the need to achieve a balance.

3.1.2 General conduct obligations

We have undertaken a considered assessment of stakeholder feedback which is described in Appendix A and of the work of Deloitte on implementation of the Scheme as described in Part 4 of this report. In Part 1 of this report, we discussed the fact that, when the Scheme was in development, it was recognised that an essential element of the Scheme was the cultural change required of insurers in the handling of claims. There is accordingly a need to measure and report on claim handling conduct, and exercise enforcement powers where conduct does not meet expectations. This includes conduct pursuant to:

- the obligation under clause 4.5 of the Guidelines to comply with the claims management principles in clause 4.6 of the Guidelines;
- the procedural provisions relating to weekly benefits in clause 4.48 of the Guidelines;
- clauses 4.76 and 4.77 of the Guidelines relating to the required approach to the management of treatment and care; and
- the general duties of insurers in connection with claims under Division 6.2 of the Act.

Recommendation 2

SIRA consider developing, implementing and reporting on measures of insurers' procedures to comply, and actual compliance, with overarching obligations relating to statutory benefits claims, including under clauses 4.5, 4.48 and 4.76-77 of the Guidelines, and Division 6.2 of the Act.

Rationale*: All stakeholders in the Scheme are working to support injured persons who need to access the Scheme and this includes getting the right culture in the handling of claims.*

The value in transparent oversight of compliance with obligations will be important, but not determinative, of achieving the right conduct outcomes. We consider that it is well known and recognised in the insurance industry and beyond, that a sound institutional culture is important for organisations to perform to high

[30] See Appendix A to this report.

standards of governance and compliance, as well as conduct themselves in a manner which meets community expectations.

Schedule 3A of the Guidelines ('Culture requirements for insurers') requires insurers to document certain plans relating to the institutional culture. However, Schedule 3A does not contain express terms to assist SIRA to hold insurers accountable to those requirements. We consider that the Scheme would benefit if SIRA had this assistance. We expect that each insurer is already committed to achieving the right culture within its organisation. We consider accountability for meeting the requirements of Schedule 3A should reinforce that to which insurers are already committed and provide further impetus for the Scheme to meet all of its Objectives.

Recommendation 3

SIRA consider:

(a) amending Schedule 3A of the Guidelines to add an obligation requiring the insurer to report to SIRA on the outcomes of the processes and structures detailed in the insurer's business plan in accordance with clauses 3.16, 3.17 and 3.18 of Schedule 3A of the Guidelines; and

(b) if SIRA has concerns about risk culture and requires insurers to make changes or undertake remedial actions to address those concerns, publishing SIRA's concerns and requirements for insurers.

***Rationale**: Insurers submit plans to meet cultural requirements. They must also be held accountable for achieving those plans.*

3.1.3 Support for claim management

The Review received feedback from several stakeholders – not limited to injured persons or plaintiff lawyers – that claim handling and decision-making in the Scheme is, at times, insensitive, unresponsive or otherwise poor. Several of the injured persons to whom we spoke relayed negative experiences with the persons assigned by the relevant insurer to manage their claim. Their experiences appeared to be the result of a lack of relevant education, experience or training, or a case-load that was too high.

A poor experience by a cohort of injured persons in respect of their interactions with claim managers was apparent in the November 2020 *SIRA Regulatory Measurement of Customer Experience and Outcomes Study* commissioned by SIRA (**Customer Experience and Outcomes Study**).[31]

In its summary of this report, SIRA concluded that certain groups of injured persons in the Scheme:[32]

> *tended to report poorer experience and outcomes. This includes people who are in the schemes for longer, have mental illness claims, symptoms of probable serious mental illness, or are experiencing pain. While good customer experience does not directly lead to recovery, this study has shown that it is an important foundation to people achieving optimal health and social outcomes.*

SIRA also stated that one of the key insights from the report was the following:[33]

> *This study has identified areas that SIRA and insurers can focus on to improve customer experience and outcomes. On the customer service front, the lowest scoring* Customer Service Conduct Principle *for both schemes related to insurers resolving a person's concerns quickly. This presents a tangible focus for insurers moving forward. In terms of health outcomes, the early identification of probable mental illness and*

[31] Social Research Centre, *SIRA Regulatory Measurement of Customer Experience and Outcomes Study*, November 2020. See, for example, section 2.1.1 ('CTP experience with insurer').

[32] SIRA, *Summary of the SIRA customer experience and health outcomes study*, Undated.

[33] Ibid.

pain, as well as opportunities for safe return to work and activities, will facilitate improved recovery and experience.

The majority of injured persons will have an experience with the Scheme that is not of the kind described above. Many claims management personnel will be working hard to perform their roles in an empathetic, supportive and responsive manner. Many will be very experienced and carry out their role with a high degree of skill and competence. While that is so, it is nevertheless important that insurers are required, from an institutional point of view, to give appropriate support to claim managers in their roles. We note also that in many aspects of the Scheme, claimants are in a position of dependence in respect of the decision-making of insurers. We consider that a critical path to improving performance is investment in support of the 'front line' of the Scheme – the claims personnel of insurers.

In our view, SIRA should have the power to set standards in the Guidelines for the qualifications, education and training, performance assessment, case-loads, and remuneration of insurer personnel involved in decision-making in relation to claims by injured persons.

A power to issue Guidelines in this respect would give SIRA an important tool to support the claim management conduct of insurers. Insurers should be supported to invest in a high quality of decision-making, and restricted from measuring or rewarding performance of the claim management function that is not carried out in the interests of the injured person. For this reason as well, SIRA should have the power to set standards, and SIRA should issue relevant Guidelines under that power.

In making this recommendation, we do not make any assumption as to particular qualifications or formal education that are needed by claim management personnel. Further, where appropriate the Guidelines could specify experience requirements that are an alternative to particular qualifications or formal education.

Recommendation 4

The legislature consider amending the Act to authorise SIRA to issue Guidelines with respect to the qualifications, education and training, performance assessment, case-loads, and remuneration of insurer personnel involved in decision-making in relation to claims by injured persons.

SIRA should use that power to issue Guidelines including minimum qualification, education, experience and training requirements, restrictions on the criteria for performance assessment and remuneration of such personnel, and standards in respect of case-loads.

Rationale*: The insurer's staff should be supported to have the capacity, skills and appropriate incentives they need to support injured persons.*

3.1.4 Approval of reasonable and necessary treatment and care

Under clause 4.74 of the Guidelines, an insurer "may approve access to treatment before a claim is made but after notification of injury has been given." Under clause 4.75 of the Guidelines, this approval is "at the insurer's discretion".

In our view there is merit in submissions to the Review to the effect that the Scheme could be improved if the Guidelines were to provide for:

- a monetary limit for initial treatment and care that does not require insurer approval. Under this proposal, the relevant insurer would be obliged to pay treatment and care expenses up to a set limit upon presentation of invoices or receipts, provided that there is satisfactory notification of the injury resulting from a motor accident. For injured persons with very small claims who did not seek further access to statutory benefits, there may not be any need to lodge a complete, formal claim to enter the Scheme in the usual way; and
- specific types of treatment and care that must be paid for or reimbursed by the insurer without any requirement for approval either before or after the treatment or care is provided.

Guidelines of this nature could reduce the need for insurer decision-making, reduce the need for injured persons to interact with the insurer, reduce disputation and delay, and enhance the autonomy in the Scheme of injured persons. In these ways, they could improve the experience of injured persons within the Scheme.

Recommendation 5

The legislature consider amending the Act to authorise SIRA to provide in the Guidelines for:

(a) types of treatment and care that are taken to be reasonable and necessary in the circumstances for the purposes of section 3.24(2) of the Act; and

(b) treatment and care costs, incurred in defined circumstances, that are taken to be reasonable for the purposes of section 3.24(1)(a) of the Act.

SIRA should use that power to issue Guidelines specifying relevant types of treatment and care, and relevant treatment and care costs incurred in defined circumstances.

***Rationale**: Where possible and reasonable, the Scheme must help injured persons to make their own decisions about what is the right treatment and care for them, and help insurers to provide cover for treatment and care with a minimum of formality where the circumstances reasonably allow.*

3.1.5 Insurer decision-making about treatment and care

As explained above, the 'reasonable and necessary' qualification to the relevant insurer's liability to pay for treatment and care means that the insurer will not pay for treatment and care unless it agrees with the recommendation of the treating practitioner. The qualification has the indirect effect of putting authority to make treatment and care decisions into the hands of the insurer and therefore has a significant impact on an injured person's interaction with the Scheme. For the majority of claimants the role of an insurer in making treatment and care decisions will have little practical impact, as the majority of treatment and care gets approved and paid. For some claimants, it can limit or delay their ability to access the treatment care that is prescribed for them.

We received feedback from multiple stakeholders, including injured persons, medical and allied health organisations, lawyers and the IRO, to the effect that insurer decision-making about treatment and care can have negative consequences for injured persons, whether in terms of accessing the treatment and care that they need, accessing that treatment and care in a timely way, or increasing physical or psychological stress to injured persons who are waiting for treatment and care to be approved or in a dispute with the relevant insurer. We also received feedback that insurer decision-making about treatment and care can reduce health practitioners' confidence in the Scheme.

We know that the CTP insurers will consider their primary focus to be supporting customers and paying valid claims. Further, insurers are good at complying with their legal obligations; if the law requires one of the Scheme's insurers to pay an amount to a claimant, then the claimant can be confident of receiving their entitlement. Insurers are also experts at pricing insurance premiums to be sufficient to fund the payment of valid claims.

However, insurers will also prudently manage their businesses in order to meet only valid claims and pay that which is needed to fulfil their obligations under the law or under their contracts with insureds. Insurers can, and should, be expected to manage claims in a way that does not draw more from their resources than necessary to operate their businesses in accordance with their obligations. In this regard, there is an important point to understand about the nature of insurers' obligation to pay for treatment and care in the current framework.

The Act does not define insurers' obligation to pay statutory benefits for treatment and care in a way that draws a sharp line between expenses that the insurer is, or is not, liable to pay. The Act effectively gives insurers a discretion to form their own view about what treatment and care expenses they are liable to pay and to act on that view, irrespective of the opinion of an injured person's treating health practitioner.

If the insurer's view about what treatment and care is 'reasonable and necessary' in a given case is later found to be incorrect as the result of an independent dispute resolution process, there is no consequence to the insurer other than that the decision is corrected; its liability remains, as it always was, to pay the reasonable cost of reasonable and necessary treatment and care for the injured person.

The point to understand is that well-meaning and competent claim managers are not always all that is required to ensure that insurers exercise their decision-making authority about treatment and care in the best interests of injured persons to advance Objective (a), and with due regard for the recommendations of treating practitioners. As an institution, the business imperative on insurers is to achieve overall claim costs at a level which is less than that for which they priced the claims cost in their portfolio. In relation to treatment and care decisions – where there is no clear dividing line between what the insurer is, and is not, liable to pay – this may mean expecting claim managers to exercise the discretion given to them on the basis of a relatively narrow view of what is 'reasonable and necessary'.

We expect that different insurers will have a different notion of exactly what this means for their management of claims and their internal governance of claim-related decision-making. The imperative to minimise claim costs within the bounds of a reasonable view of liability is not the only imperative on insurers, and in many claims will have no direct significance at all. Undoubtedly all of the CTP insurers strive to manage claims in a way that they consider to be fair and reasonable. In most cases, it will be clear what treatment and care is 'reasonable and necessary' and the claimant and insurer will be on common ground. However, in our view the issue is how to ensure that the framework supports insurers to make decisions about treatment and care that are consistent with the Objectives of the Act and strike the right balance between the interests of injured persons and insurers.

For the purposes of achieving Objective (a), we consider that the starting point in the design of the framework should be that the insurers are obliged to pay the reasonable cost of treatment and care that injured persons' treating practitioners recommend. That would be a clear, definite obligation of insurers with which they could easily comply. It would not create any institutional pressure on insurers to impose on the injured person a more limited view than that of the treating practitioner as to what will be regarded, subject to the dispute resolution procedures, as 'reasonable and necessary' treatment and care.

It is then necessary to consider what flexibility for the insurer is needed to ensure that expenditure on claims within the Scheme is not unconstrained. In our view, that oversight does not require a complete transfer to the insurers of authority to make treatment and care decisions.

One mechanism that the Act already includes is that injured persons (and therefore insurers) cannot be required to pay more than the applicable Australian Medical Association rates for the treatment and care.[34]

In our view, the 'reasonable and necessary' qualification to insurers' liabilities – with adjustment – could still have an important role. It can give insurers a mechanism to ensure that they do not have to pay for treatment and care that represents 'over-servicing'. However, the qualification should operate in a more constrained way. We consider that amendments to 3 aspects of the Scheme could achieve this. The first amendment is the key adjustment to the qualification on the insurer's obligation to pay for treatment and care. The second and third amendments are necessary to ensure that the adjusted qualification works appropriately and insurers are able to exercise necessary oversight of claims.

First, a presumption should apply to treatment and care for an injured person that is recommended in writing by the treating health practitioner, so that it is presumed to be:

- 'reasonable and necessary'; and
- related to the injury resulting from the motor accident concerned, if certified by the treating practitioner to be related.

This will help to give certainty and assurance to an injured person that the insurer will pay for the recommended treatment and care (rather than exercise its own discretion as to whether to pay for recommended treatment and care). The insurer must have its interests protected in this situation. We propose that the protection will still be adequate even if an insurer wishing to withhold treatment and care expenses is required to have evidence that can establish and support a contrary recommendation to that of the treating practitioner.

[34] Section 3.31(4) of the Act and clause 4.95 of the Guidelines.

Second, in cases where the presumptions above apply, our Recommendation 7 should be implemented to prohibit insurers from requesting an injured person to undergo a medical or other health related examination to determine whether treatment and care is reasonable and necessary or related to the motor accident. If insurers could require such examinations, this could undermine the presumptions. (Note that Recommendation 7 is required to support the above presumptions, but is not made solely for that purpose.)

If evidence to rebut the presumptions is not already on the claim file or available from the injured person's treating practitioner, the practical effect would be that an insurer wanting to refuse treatment or care recommended by the treating practitioner would have to refer the matter as a medical dispute for medical assessment in the Personal Injury Commission (**PIC**) under Division 7.5 of the Act.[35]

Third, the Act should incorporate a framework to discourage insurers from lodging disputes unless there is a sound basis to do so. Specifically, if the presumptions we propose are introduced, there must be consequences for lodging 'treatment and care' disputes that do not have merit. This is the subject of our Recommendation 27 (which has a broader scope and purpose than just the issue under discussion here).

SIRA should be able to specify circumstances when one or both of the presumptions do not apply. For example, SIRA might identify, in consultation with health professionals, certain potential treatment and care recommendations (e.g. a volume or frequency of a particular treatment, or a particular type of treatment for a particular type of injury) that are outside the range of accepted standard treatment and care currently employed in competent medical or allied health practice. SIRA should be able to specify that the presumption as to reasonableness and necessity does not apply to recommendations that have been so identified. Guidelines of this kind would probably need to be kept under regular review in consultation with health professionals.

Recommendation 6

The legislature consider amending the Act to provide that treatment or care recommended in writing by a treating practitioner is, subject to evidence to the contrary:

(a) presumed to be reasonable and necessary in the circumstances; and

(b) if certified by the treating practitioner, presumed to relate to the injury resulting from the motor accident concerned.

The amendment should provide for SIRA to specify in the Guidelines circumstances in which one or both of the presumptions do not apply.

***Rationale**: A doctor or other treating practitioner is generally the best person to decide what treatment and care someone needs. Injured persons should generally have the choice as to whether to accept the recommendations of their treating practitioners.*

3.1.6 Medical or other health-related examinations

Section 6.27 of the Act requires claimants to comply with a request by the insurer to undergo a medical or other health-related examination, a rehabilitation assessment, assessment to determine attendant care needs, or an assessment to determine functional and vocational capacity. It is based on section 86 of the 1999 Act. However, the 1999 Act only concerns damages claims whereas section 6.27 applies to both statutory benefits and damages claims.

Medical or health examinations by non-treating practitioners to determine reasonable and necessary treatment and care are, at the initial decision-making stage, not consistent with early access to reasonable and necessary treatment and care. We recommend that insurers should not be able to require injured persons to undergo a medical or other health-related examination if treatment and care has been

[35] See Recommendation 27 relating to insurers' overturn rates in the PIC.

recommended in writing by the treating practitioner. This would support insurers to rely on information given by treating practitioners. A doctor or other treating practitioner is generally the best person to decide what treatment and care their patient or client needs.

If Recommendation 6 is implemented, then this further recommendation is strictly necessary.

Suncorp made a submission to the effect that its approach is along the lines of this recommendation but, based on feedback to the Review, this is not the universal approach of insurers.

Our recommendation would not prevent the insurer from, in relation to statutory benefits, getting an independent assessment for the purposes of decisions as to 'minor injury', work capacity, or whether treatment and care for a 'minor injury' will continue improvement after 26 weeks. In relation to damages claims, clause 4.137 of the Guidelines sets out some limitations on a claimant's obligation to comply with an insurer's request for a medical examination and, while these appear to us to be appropriate for damages claims, in our view they are not sufficient for statutory benefits claims.

Our Recommendation 8 (below) would effect changes to the framework for rehabilitation assessment, assessment to determine attendant care needs, or an assessment to determine functional and vocational capacity (i.e. the other types of assessments contemplated by section 6.27 of the Act).

SIRA should be able to specify circumstances when the prohibition on requiring injured persons to undergo a medical or other health-related examination does not apply.

Recommendation 7

The legislature consider amending the Act, in relation to determining whether any treatment and care provided to the injured person in accordance with a written recommendation by their treating practitioner is reasonable and necessary in the circumstances or, if certified by the treating practitioner, relates to the injury resulting from the motor accident concerned:

(a) to prohibit insurers from requesting the injured person to undergo a medical or other health related examination;

(b) to allow insurers to request additional information from a treating practitioner; and

(c) to provide that an insurer who wishes the injured person to undergo a medical or other health related examination must lodge a medical dispute with the PIC.

The amendment should provide for SIRA to specify in the Guidelines circumstances in which the restriction in (a) does not apply.

***Rationale**: A doctor or other treating practitioner is generally the best person to decide what treatment and care someone needs. The Scheme needs to support insurers to rely on information given by treating practitioners.*

3.1.7 Health-related assessments

In addition to medical or other health-related examinations, section 6.27 enables insurers to require a range of other important assessments, including:

- rehabilitation assessments;
- assessments to determine attendant care needs; and
- assessments to determine functional and vocational capacity.

We understand that assessments of this nature are typically undertaken by a provider who is contracted to the insurer to do work of this nature. Some stakeholders are concerned that such arrangements have the potential to undermine the work of providers because, while the assessment should be independent and disinterested, in practice a provider who is contracted to the insurer may not provide assessments that are always balanced and fair.

While we make no criticism of providers or the insurers to whom they are contracted, we have concluded that injured persons are entitled to expect that assessments are properly independent. There is no need for assessments to be undertaken by organisations that are contracted to either of the parties who have an interest in the outcome of the assessment.

We consider that it should be feasible for assessment providers participating in the Scheme to be contracted to SIRA rather than the insurers. When an assessment is needed, SIRA would appoint a provider from its panel. The insurers would continue to pay for their work.

Our recommendation in this regard also addresses an issue raised in feedback to the Review where the rehabilitation provider can, on occasion, become a quasi-investigator for the insurer. It may also facilitate increased access by injured persons to professional care where it is reasonable and necessary.

Recommendation 8

SIRA consider:

(a) developing a panel of rehabilitation providers and occupational therapists, contracted to SIRA and not insurers, who would have responsibility to provide any:

  (i) rehabilitation assessment;

  (ii) assessment to determine attendant care needs; or

  (iii) assessment to determine functional and vocational capacity; and

(b) amending the Guidelines to provide that, for the purposes of sub-sections (b) and (c) of section 6.27(1) of the Act, any assessment of these matters otherwise than by a treating practitioner must only be undertaken by a member of the panel (or an employee or contractor of a member of the panel).

***Rationale**: Persons playing a key role in helping recovery should be independent so that they are supported to focus on understanding the needs of the injured person.*

3.1.8 Patient and practitioner relationship

We understand that it is necessary sometimes for an insurer to contact an injured person's treating practitioner directly. Feedback to the Review indicates that this sometimes occurs without notification and disclosure to the injured person concerned. Consistently with feedback to the Review, in our view if an insurer interacts with a treating practitioner without making a full disclosure to the injured person, then this has the potential to impact negatively on the injured person's experience in the Scheme. It could also have the potential to undermine Recommendation 6 relating to the acceptance of written recommendations from the treating practitioner.

We consider that it is consistent with the duties of an insurer under section 6.3 of Division 6.2 of the Act (which addresses the duty to act with good faith) that engagement with a treating practitioner be transparent. We expect that it should be a simple matter for properly resourced and trained claim management personnel to keep the injured person informed about their contact with treating practitioners.

We have received feedback that there are occasions where the insurer requires the attendance of a representative (such as a rehabilitation provider who is appointed by the insurer) to attend a consultation between the injured person and their treating practitioner. In our view, this could be invasive and has the potential to be detrimental to the injured person and their relationship with their treating practitioner. We recommend that the insurer's attendance at such consultations should not be allowed.

Recommendation 9

SIRA amend Part 4 of the Guidelines to:

(a) prohibit insurers or any person appointed by insurers from attending a private consultation between an injured person and a treating practitioner occurring in the ordinary course of the injured person's treatment and care that relates to the injury resulting from the motor accident concerned; and

(b) require insurers to give written notification to the injured person concerned of any communication (whether written or otherwise) between the relevant insurer and an injured person's treating practitioner, including the matters discussed and the outcome of the communication.

***Rationale**: The practitioner/patient relationship is private and confidential.*

3.1.9 Additional matters

Recovery plans

Feedback to the Review, and the reviews commissioned by SIRA of the first 1,000 claims, highlighted both that recovery plans are often not present or are of variable quality, and that recovery plans can assist the return to work and usual activities of injured persons.

The Guidelines require all claimants to have a tailored recovery plan, subject to certain exceptions.[36]

Recommendation 10

SIRA consider taking steps to ensure compliance by insurers with their obligations under clauses 4.76 to 4.90 of the Guidelines relating to recovery plans for injured persons, and to ensure that recovery plans are of a high standard and address not only return to work but also return to other activities.

***Rationale**: A plan for recovery will help injured persons.*

Australian Medical Association (AMA) rates for treatment and care

Section 3.31(4) of the Act provides that:

> An injured person is not liable to pay, and a person is not entitled to recover from an injured person, the cost of treatment and care provided in respect of an injury suffered in the motor accident concerned if, and to the extent that, the cost of treatment and care exceeds any limit imposed by the Motor Accident Guidelines in respect of the treatment and care.

Clause 4.95 of the Guidelines provides that:

> In terms of section 3.31(4) of the Act, the limit is the applicable Australian Medical Association (AMA) rates at the time the treatment/service is provided.

We have received feedback that insurers at times require the injured person to self-fund a gap between the AMA rate and the actual cost of treatment and care. This is understandable if an injured person has reasonable and necessary treatment available to them from a practitioner who will charge the AMA rate but elects to be treated by a practitioner who will charge above the AMA rate.

However, the situation is different if treatment and care is not reasonably available from a practitioner who will charge only the AMA rate. For example, we received feedback from an injured person that they were expected by their insurer to contribute a substantial amount to the cost of essential, highly specialised major

[36] See clauses 4.76 to 4.94 of the Guidelines.

surgery in circumstances in which it could only be undertaken by one surgeon in New South Wales, who charged above the AMA rate.

In our view, such a position is not consistent with section 3.31(4) of the Act but the correct outcome for that situation is not made clear by clause 4.95 of the Guidelines. The question arises as to how prevalent in the Scheme is this situation. Deloitte recommend an independent claim file review directed to a number of issues, covering the adequacy and ongoing nature of financial support. Such a review could also consider this issue. If there are particular treatments or surgeries which are not generally available from practitioners charging the AMA rates, then the next question is how the Guidelines should deal with the situation where reasonable and necessary treatment and care at the AMA rate is not reasonably available to the injured person.

Recommendation 11

SIRA consider:

(a) consulting with relevant medical stakeholders and, if considered necessary, undertaking research to determine the extent to which certain treatment and care is not reasonably available at AMA rates; and

(b) whether it is necessary to amend clause 4.95 of the Guidelines to ensure that insurers pay the reasonable cost of treatment and care above AMA rates in circumstance where equivalent treatment or care is not reasonably available at AMA rates.

Rationale*: Insurers should pay for the treatment and care that is needed and available.*

Participation in the Scheme by practitioners

We have had feedback from several stakeholders, including treatment and care providers, to the effect that many providers refuse to provide treatment and care funded by statutory benefits because of the administrative burden of doing so.

Objective (a) will be severely constrained if the feedback is correct that many providers refuse to provide treatment and care funded by statutory benefits because of the administrative burden of doing so. The more treatment and care providers participating in the Scheme, the greater the opportunity for injured persons to find a treating practitioner of their choice and the potential for improved outcomes for that person.

In our view, SIRA should seek to understand the prevalence and causes of these issues with a view to addressing them.

Recommendation 12

SIRA consider undertaking research to determine precisely the barriers to participation in the Scheme by providers of treatment and care, and the measures that could be taken to remove or reduce those barriers, in order to enable injured persons to have the provider of their choice.

Rationale*: All providers of treatment and care should be supported to participate in the Scheme.*

Timing of insurer decisions about treatment and care

Clause 4.99 of the Guidelines provides as follows:

> Where the insurer determines the claimant's request for treatment, rehabilitation, vocational support and attendant care services, it must advise the claimant and service provider in writing as soon as possible but within 10 days of receipt of a request…

In feedback to the Review, the IRO raised an issue where this clause could be interpreted as only placing an obligation on the insurer to advise the claimant and service provider of its determination *after* the insurer has actually made the determination on a request for treatment or care. We understand that concern. The IRO submits, and we agree, that the legislation could be strengthened to provide that the insurer must determine

the claim within the specified time frame. The Guidelines should make clear that the 10 day period runs from the date on which the insurer receives the claimant's request for treatment, rehabilitation, vocational support and attendant care services.

Recommendation 13

SIRA should amend clause 4.99 of the Guidelines to clarify that the insurer is required to issue its decision in relation to treatment or care within 10 days of receipt of the claimant's request, whether the request is for pre-approval to pay statutory benefits for the treatment or care or for the payment of statutory benefits for treatment or care that has already been provided.

***Rationale**: Decisions about treatment or care affect the health and wellbeing of injured persons and must be quick.*

3.2 Objective (b) – Financial support

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

3.2.1 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.[37]

The statutory entitlement to weekly benefits, rather than reliance on claiming damages for lost earnings, is intended to facilitate early financial support.

Key factors for calculation of the payments in the first 78 weeks after the motor accident include the injured person's 'pre-accident weekly earnings' (**PAWE**) and their 'post-accident earning capacity', as well as a discount percentage which ensures that weekly payments are less than pre-accident earnings.

After 78 weeks, 'pre-accident earning capacity' replaces 'pre-accident weekly earnings' in the calculation. This has the effect that injured persons who were not earning an income before they were injured may nevertheless receive income support if, after 78 weeks, their capacity to earn income is still reduced as a result of the accident. This mitigates the loss to a person who, although not earning an income at the time of the accident, would have been earning an income by 78 weeks later if the accident had not occurred. However, the calculation will result in some injured persons receiving weekly payments even though they would not have been earning an equivalent income.

Schedule 1 to the Act and Part 4 of the Guidelines set out detailed provisions for the meaning of 'earner', 'loss of earnings', 'pre-accident weekly earnings' (including different meanings for different categories of injured person), 'post-accident earning capacity', and 'pre-accident earning capacity', as well as the matters to be taken into account in the calculation of weekly payments.

The provisions governing weekly payments are inherently complex in proportion to the closeness of the match that the Scheme seeks to achieve between an injured person's actual lost income and the amount of weekly payments they receive.

There are prescribed maximum and minimum weekly payment amounts, which operate both to limit the upper end of such amounts and to ensure that all eligible injured persons receive a minimum weekly payment.[38]

Maximum period of weekly benefits

Weekly payments cease after 26 weeks if a person's injuries are exclusively 'minor injuries'.[39]

For persons who have a non-'minor injury', weekly payments also cease after 26 weeks if the accident concerned was caused 'wholly or mostly by the fault' of the injured person.[40] For persons who are not considered to be wholly or mostly 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.[41]

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[37] Division 3.3 of the Act.

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

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

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

[41] Section 3.38 of the Act.

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 greater than 10%) or 260 weeks (if permanent impairment is greater than10%).[42] If the pending damages claim is withdrawn, settled or finally determined then the weekly payments cease.[43] There is also provision for the termination of payments when an injured person reaches retiring age,[44] or 12 months after retiring age if the injury happens after retiring age.[45]

The reason why weekly payments can continue past 104 weeks if there is a pending damages claim is so that financial support remains ongoing while the damages claim is resolved. This has the effect that persons who are injured in a single-vehicle accident through no fault of their own are limited to 104 weeks of income support, while persons who are injured through the fault of another driver can continue to receive weekly payments past 104 weeks. Feedback to the review generally supported this aspect of the Scheme, and we agree that it is the appropriate outcome in a Scheme that has a basic intention to provide 2 years of financial support and only provides lifetime financial support to those who have an entitlement to claim damages.

This aspect of the framework creates the potential for an injured person who has no entitlement to weekly payments after 104 weeks and no one to sue for damages, nevertheless to lodge a claim for damages which is unmeritorious for the sole purpose of continuing to receive weekly payments while the damages claim is pending. A law firm submitted that they do, in fact, see such damages claims being made.

The law firm submitted that, for all persons, weekly payments should be available for a maximum 52 weeks, including for claimants who are not at fault and may be able to claim damages. This would greatly simplify the weekly payments aspect of the Scheme and remove the ability to access weekly payments through the expedient of lodging an unmeritorious damages claim. Insurers would have the ability to maintain ongoing financial support to those who need it by way of 'advance payments' of compensation to those who lodge a claim for damages, and special provisions could apply to catastrophically injured persons.

This proposal is attractive in several ways, because of the potential to simplify the framework for early and ongoing financial support and the removal of any advantage to lodging unmeritorious damages claims. One of the concerns we have with the proposal is that, although insurers could make advance payments where they concede liability,[46] there would inevitably be some injured persons who lose weekly payments but do not receive alternative support from the insurer because the insurer does not concede liability, even though ultimately the insurer may be found liable to pay damages. Currently such persons receive ongoing financial support while the damages claim is resolved. In any event, as explained further below, amendments to the Scheme to simplify the framework for achieving this objective require further consultation on proposals for change.

Information obligations on claimants

There are obligations on injured persons claiming weekly payments to provide to the relevant insurer:[47]

- information about a change in circumstances

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

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

[44] '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.

[45] Section 3.13 of the Act.

[46] That is, concede that the at-fault driver whom it insures is liable to the claimant to pay damages, in respect of which the insurer will indemnify the at-fault driver.

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

- 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.

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.[48] 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.[49] The Act also provides for weekly payments to injured persons residing outside Australia in certain circumstances.[50]

Submissions about the complexity of the framework

We received submissions, from those who need to put the provisions governing weekly payments into practice, that the framework for early and ongoing financial support needs amendment. The Law Society of NSW's position is that:[51]

> *the provisions governing the calculation of PAWE* [i.e. 'pre-accident weekly earnings'] *are not working and in practice, PAWE has become one of the most complex issues in the Scheme.*

The ICA submitted as follows:[52]

> *Insurers note that the provisions are complex and are made more so by the location of provisions in various statutory instruments and across the Act. For example, to determine an entitlement to weekly benefits, a person undertaking the assessment must refer to Part 3 of the Act, consider Schedule 1 of the Act and check the Motor Accident Injuries Regulation (Regulation), whilst acting in accordance with Part 4 of the Motor Accident Guidelines (Guidelines) which contains additional conduct expectations including decision making principles (unique to decisions on weekly benefits). Insurers believe simplification would improve claimant and insurer understanding, decision making and claimant experience.*

A law firm that represents insurers in the Scheme made detailed submissions regarding issues in the weekly payments framework, including that "*the stages of entitlements and the shifting thresholds during the duration of a claim, sees the 'ongoing' financial support unnecessarily difficult for all involved*" resulting in "*a system that is far too technical to navigate for any self-represented claimant*". This firm also submitted that the provisions governing verification of earnings need amendment to assist insurers to determine the correct amount of weekly payments without delay, and that the detailed provisions for calculation of weekly benefits are not only difficult to apply but can lead to poor outcomes both for injured persons and the Scheme generally.

We have considered the provisions and can readily accept the submissions made about them. They are complex and we can understand that, in practice, they are difficult to implement. Having said that, we are not in a position to recommend specific amendments to the weekly benefits framework to resolve the many issues raised by stakeholders. Solutions to the issues require further investigation and consultation with stakeholders who have first-hand experience applying the framework and seeing the results. The timeframe for our work in this Review did not allow us to undertake that investigation and consultation.

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

[49] Section 3.20 of the Act.

[50] Section 3.21 of the Act.

[51] Law Society of NSW, *Submission to Review*, page 8.

[52] ICA, *Submission to Review*, page 9.

Finally, Deloitte recommends consideration by SIRA of introduction of a 'complex claims team' in the CTP Assist service, including a capacity to support claimants in respect of weekly payment calculations. The scope of such a capacity could be considered in the review we recommend below.

Additional observations about complexity

In its submission to the Review, Suncorp raised an issue about the definition of PAWE in Schedule 1 to the Act, as it applies to those who are self-employed. The issue was said to be that, "a self-employed person's PAWE is their weekly average of the gross earnings they received in the 12 months immediately before the date of the accident. Their gross earnings are their business' gross income less expenses."[53] Suncorp propose that the Act should be amended to avoid outcomes that are unfair, as seen in the following example:[54]

> *Example: where the injured person earns $1,000 in gross sales every week but has a fixed expense of $600 per week for rent, we would determine PAWE to be $1,000 - $600 = $400. However, the injured person must still pay $600 in rent every week, and therefore is at a loss after we pay them their weekly benefits.*

For our part, it is not clear to us that the provisions of Schedule 1 to the Act lead to this result. Under clause 3 of Schedule 1, a person's "loss of earnings" includes lost "income from personal exertion", which in turn includes (relevantly to persons who are self-employed) "the proceeds of any business carried on by the person either alone or in partnership with any other person". Certain sources of income are excluded from this, and one of those sources is "rents".[55] However, "rents" is not specified as a deduction from "income from personal exertion", and it is not clear to us that a self-employed person's fixed costs by way of rent should be deducted from the weekly payment amount.

In the ICA's submission to the Review, it raised a concern on behalf of the insurers about the Motor Accidents and Workers Compensation Legislation Amendment Bill 2021 (**Bill**) which is currently before the Parliament. The Bill would, among other things, amend clause 4(2)(b) of Schedule 1 to the Act, to align better with clause 4(3).

Ordinarily, PAWE is essentially the weekly average of a person's earnings during the 12 months before the accident. Clause 4(3) of Schedule 1 to the Act describes the situation where, during those 12 months, a person started earning, or became entitled to earn, more than previously. Clause 4(2)(b) provides that, in the situation described in clause 4(3), PAWE is the weekly average of the person's earnings after the change occurred. There is a slight misalignment in these provisions, because clause 4(3) can be satisfied if a person *becomes entitled* before the accident to earn more than previously and not only if the person *starts earning* more than previously; however, the calculation in clause 4(2)(b) only works if the person *started earning* more than previously before the accident occurred. For example, if a person receives a promotion with a higher rate of pay that is scheduled to start in 2 or 3 months, but is injured in a motor accident before it starts, then clause 4(2)(b) would be satisfied but PAWE under clause 4(2)(b) would still be calculated at the lower rate of pay because the person's earnings were unchanged in the period after being given the promotion but before the accident. The amendment in the Bill will correct this if it becomes law, so that PAWE is calculated by reference to the 12-month period beginning when the person received the promotion.

The ICA has a different understanding of the intent of the proposed amendment to clause 4(2)(b), to the effect that the amendment seeks to pick up an entitlement that was likely to arise after the accident, but did not arise because of the accident. On this understanding, the amendment will not work unless there is also an amendment to clause 4(3). On the ICA's interpretation, there is an error in the Bill and "the proposed amendment to clause 4(2)(b) will not result in higher benefits to injured people."[56]

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[53] Suncorp, *Submission to Review*, page 7.

[54] Id.

[55] Clause 3(3)(b) of Schedule 1 to the Act.

[56] ICA, *Submission to Review*, pages 9-10.

We make these additional observations to illustrate the complexity of the provisions and the difficulty associated with understanding and applying them correctly. The weekly benefits provisions may remain a relatively complex area of the Act even after amendment. However, the experience to date of insurers and lawyers who are stakeholders in the Scheme could be brought to bear to simplify them so that there is less room for delay, error by insurers or misunderstanding by claimants, and ultimately dispute.

Recommendation 14

SIRA should undertake a review of the weekly payments framework, to assess what steps can be taken to enable a greater proportion of earners to receive their full entitlement sooner and to minimise disputes. The review should consider, among any other matters considered relevant, whether:

(a) the provisions for determining the appropriate amount of weekly payments for earners can be simplified, including consideration of whether weekly payments should be made on the basis of a set statutory rate, or rates dependent on the nature of the injured person's pre-accident employment or pre-accident training, skills and experience;

(b) the provisions for calculating weekly payments in the post-second entitlement period remain appropriate;

(c) the Act or Guidelines should be amended to enable faster and better access to relevant information by insurers for the purpose of calculating the required amount of weekly benefits; and

(d) guidance is required as to how disputes in relation to weekly benefits should proceed in the PIC, having regard to the provisions currently in clauses 1(a) and 2(d) of Schedule 2 to the Act.

Rationale*: There is now enough experience in the Scheme to refine the provisions governing financial support by way of weekly payments. Many stakeholders agree that the provisions present a range of difficulties and can be improved. This could lead to faster and better handling of claims from the perspective of injured persons.*

3.2.2 Late lodgement of statutory benefits claims

If a claim for statutory benefits is not made within 28 days of the accident, then weekly payments are not payable in respect of the period after the accident but before the claim was made.[57] There is no mechanism for relief for an injured person even if they miss this deadline through no fault of their own, including where a person's injuries themselves make lodgement of a claim within 28 days impossible. A simple and obvious example is the position of a person hospitalised in intensive care during that period. There will be other less severe cases of injury that will nevertheless, in the circumstances, impede a person's ability to meet the deadline.

The position of several stakeholders is that this rule can lead to unfair outcomes and that the Act requires amendment to allow flexibility to avoid unfairness. In relation to some other time limits on claimants, the Act provides a mechanism for flexibility where the claimant provides a 'full and satisfactory' explanation for the delay. In our view, this should apply to the back-payment of weekly payments in relation to statutory benefits claims lodged more than 28 days after the accident concerned.

In making this recommendation, we recognise that injured persons who have an entitlement to damages should be able to recover the lost weekly payments as part of a lump-sum compensation payment for economic loss. However, most claimants are not entitled to claim damages[58] and in any event the

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

[58] This is because the majority of claims in the Scheme are by persons who either have only 'minor injuries' or are at fault in respect of the motor accident concerned.

framework should provide for back-payment sooner than will occur if the claimant has to wait for resolution of a damages claim.

Recommendation 15

The legislature consider amending the Act to make weekly payments of statutory benefits payable in respect of the period before the claim is made even if the claim is made more than 28 days after the date of the motor accident, if the claimant provides a full and satisfactory explanation for the delay.

***Rationale**: An inflexible rule for the timing of claims can operate unfairly for some of the most seriously injured persons.*

3.2.3 Commencement of weekly payments

Section 3.6(1) of the Act provides that an 'earner' who is injured as a result of a motor accident and suffers a loss of earnings as a result of the injury is entitled to weekly payments.

An issue was raised in feedback to the Review that delays occur in payment of statutory benefits where there are delays in calculation of the relevant entitlement.[59]

Section 3.6(5) provides that, if weekly payments are payable, but further information is required to determine the amount of the payment, interim payments are to be made in accordance with the Guidelines until the correct amount of the payment can be determined and paid. Clause 4.44 of the Guidelines provides that the interim amount is 12.5% of the 'maximum weekly statutory benefits amount' that is payable under the Act. This amount is also the 'minimum weekly statutory benefits amount' that is payable under the Act.[60]

In our view, once the insurer has identified that the claimant is an 'earner' who is injured as a result of a motor accident and has suffered a loss of earnings as a result of the injury, weekly payments of at least the interim amount should begin to flow immediately.

We observe that section 6.19(1) of the Act provides that, within four weeks after a claimant makes a claim for statutory benefits, the relevant insurer must give the claimant a notice in accordance with the Guidelines stating whether or not the insurer accepts liability for the payment of statutory benefits during the first 26 weeks after the motor accident concerned. However, payment of at least the interim amount of weekly payments need not be delayed by the liability notice under section 6.19(1).

An obligation to make such payment would be consistent with – but perhaps not clearly required by – the existing provisions in the Act. We consider that this can be addressed by a change to the Guidelines.

Recommendation 16

SIRA should amend the Guidelines to clarify that the relevant insurer must begin weekly payments of statutory benefits immediately after determining that a claimant is an earner entitled to weekly payments under section 3.6(1), including by making interim payments if the full entitlement has not yet been determined.

***Rationale**: Financial support should begin to flow as soon as the insurer has confirmed that an injured person is entitled to it.*

[59] IRO, *Submission to Review*, page 5.

[60] Section 3.10 of the Act and r 7 of the Regulations.

3.2.4 Damages claims

Weekly payments – statutory benefits to cover loss of income – are a temporary mechanism of financial support within the Scheme. For persons who have 'minor injuries' only or who are 'wholly or mostly' at fault, weekly payments will not continue past 26 weeks after the motor accident concerned. For persons who are not at fault, but were injured in a single-vehicle accident, statutory benefits will not continue past 104 weeks.[61]

For persons who have a non-'minor injury' and are not 'wholly or mostly' at fault, weekly payments can continue up to 156 weeks if they have lodged a damages claim that is still pending, or up to 260 weeks if they have lodged a damages claim that is still pending and the degree of permanent impairment of the person is greater than 10%. Weekly payments cease upon the withdrawal, settlement or final determination of the pending damages claim.

A common law damages claim is the mechanism by which an injured person can be compensated for lost earnings over the period not covered by weekly payments. For persons whose injuries result in permanent impairment greater than 10%, it is also the mechanism to be compensated for non-economic loss (i.e. pain, suffering, loss of amenities or loss of expectation of life).

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 be awarded damages. This issue would ordinarily be resolved in connection with the person's statutory benefits claim because it affects the entitlement of a person (who is not 'wholly or mostly' at fault) to statutory benefits after the first 26 weeks.

Second, if a person's injuries result in a degree of permanent impairment not greater than 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). There is no occasion to assess permanent impairment in connection with a statutory benefits claim. There is an associated provision in the Act which prohibits settling a damages claim before 2 years if the injured person has a degree of permanent impairment 10% or less.[62]

Submissions to the Law and Justice Review questioned whether it is necessary to have the 20-month waiting period for damages claims where permanent impairment is not greater than 10% and whether it is contrary to Objective (g). We sought further feedback in the course of this Review, including by way of specific questions in our Discussion Paper.[63] The feedback we received is summarised in Appendix A. There was no support among stakeholders for retaining the 20-month waiting period. We conclude that the delay is not beneficial to injured persons or to the orderly and timely resolution of claims.

If the 20-month waiting period is removed, then the prohibition on settling affected damages claims should also be removed. Beyond that, there is a question as to what, if anything, should replace the 20-month wait in the Scheme. There is a need to consult on specific proposals for change. This has not been possible in the relatively short timeframe for this Review which is required to consider all aspects of the Scheme. Our recommendation is as follows, but we also continue the discussion on damages claims below.

[61] This assumes that an injured person in this category does not lodge a damages claim (which would entail alleging that another person was at fault).

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

[63] Discussion Paper, Questions 26-31.

Recommendation 17

SIRA should undertake a review of the lodgement of damages claims under Part 4 of the Act which should:

(a) proceed on the basis that section 6.14 of the Act should be amended to remove the requirement for persons with whole person impairment 10% or less to wait 20 months before lodgement and section 6.23(1) of the Act should be amended to remove the 2-year prohibition on settling claims for damages; and

(b) consider, among any other options considered appropriate for consultation, amendments to the Act that would have the following effect:

  (i) an injured person with non-minor injuries wishing to claim damages for past economic loss only (i.e. not seeking to claim damages for future economic loss or for non-economic loss) could do so at any time;

  (ii) insurers be required to assist injured persons who are unlikely to have been wholly at fault and unlikely to have whole person impairment greater than 10% to lodge a claim for damages of the above nature upon the injured person's return to work within the first 12 months after the motor accident concerned; and

  (iii) any persons wishing to claim damages for future economic loss or damages for non-economic loss (in addition to damages for past economic loss) could do so only 12 months or more after the motor accident concerned; and

  (iv) despite sub-paragraph (iii), if a person is assessed within the first 12 months after the motor accident concerned as having a degree of permanent impairment greater than 10% as a result of the accident, then they may claim damages at any time.

(c) consider whether section 6.25 of the Act should be amended in respect of the timing and content of the claimant's obligation to give particulars of a damages claim.

Rationale*: All stakeholders agree that waiting 20-months to claim damages impacts injured persons and creates problems for insurers and the dispute-resolution system. Careful consideration is needed for additional changes that may be required if the 20-month wait is removed.*

The current 20-month wait applies to injured persons with a right to claim damages for *lost income only*, because they have a degree of permanent impairment of 10% or less. Any person in that category who has returned to work before lodging a damages claim will be seeking damages for *past* loss of income only. It is reasonable to expect that many injured persons in that category will return to work and maximise their return to work or other activities well before 20 months. Damages claims by persons who have recovered and returned to work – if lodged on the basis that only past economic loss is claimed and any other claim is forgone – should be relatively simple, particularly as to quantum. There is no compelling reason to delay their claim.

Twelve months is a reasonable period for other injured persons to wait before lodging a damages claim (i.e. those who have still not returned to work and/or have a degree of permanent impairment greater than 10%) because:

- if the injured person does not return to work during the first 12 months and has a right to claim damages for economic loss, then they will still be in receipt of income support throughout that twelve months; and
- for those who seek to establish permanent impairment greater than 10%, permanent impairment assessments generally have to take place more than one year after the accident in any event.

A 12-month wait for injured persons who wish to claim damages *in addition* to past economic loss would allow the framework to create an incentive for those with less severe injuries to go back to work and claim only the past loss of income, because a claim of that nature could be made sooner.

The review we recommend in Recommendation 17 ought to consider, in relation to a damages claim for past economic loss only:

1. whether it may be possible to make special provisions for damages claims of this nature to simplify and streamline the procedure to access the award of damages, if the initial assessment by the insurer is not accepted by the claimant;

2. whether the obligation on insurers to assist injured persons who are unlikely to have whole person impairment greater than 10% could include notification of the results of an initial assessment of liability (that is, fault of another person) and quantum based on the information in the claim file. In cases where it is clear that the injured person is not at fault and the quantum is also clear, the insurer could be required to offer to pay damages in the assessed amount without separate lodgement by the injured person of a claim for damages. In other cases, the insurer could be required to make an offer to the injured person based on the initial assessment or, if no initial assessment can be made or the insurer considers the injured person to be wholly at fault, notify the injured person of that fact and give guidance as to how to proceed to claim damages; and

3. the need for any notification by the insurer, in relation to a limited damages claim of this nature, to clearly inform the injured person of their potential rights to future lost income and damages for pain and suffering, which would be foregone under a settlement on the basis of past economic loss only. There should be care taken to ensure that injured persons do not compromise their rights without being fully informed and given the opportunity to seek advice.

As to assistance to claim damages rendered by insurers to injured persons: in principle, if insurers should be expected to assist claimants to get all of the statutory benefits to which they are entitled, then we consider it to be consistent with the Objectives that insurers should also be expected to assist claimants to get the damages awards to which they are entitled.

In relation to injured persons who have not yet fully returned to work, insurers could be required to notify injured persons at 9 months and again at 12 months of the right to claim damages, the criteria for an award of damages, and guidance as to how to proceed to claim damages.

Currently, section 6.25(1) of the Act requires a claimant to "provide the insurer with … all relevant particulars about the claim as expeditiously as possible after the claim is made". Section 6.25(2) states specifically what information comprises 'full particulars'. The review we recommend should consider the appropriateness of this obligation. In relation to a damages claim for past economic loss only, where the insurer knows the likely quantum of the claim because it has paid statutory benefits for lost income to the claimant, a more confined obligation to give particulars may be possible. In relation to other damages claims, consideration should be given to submissions we received to the effect that the resolution of damages claims could proceed more efficiently if the obligation to give particulars was simultaneous with the lodgement of the claim, rather than only arising "after the claim is made".

Finally in relation to Recommendation 17, some stakeholders consider that the intention of the current 20-month waiting period is in fact to discourage altogether the making of damages claims by persons with permanent impairment of 10% or less.[64] It is true that the rationale for the 20-month wait is unclear. There is a suggestion that the wait is intended to allow maximum recovery from injury before damages are claimed,[65] but it is hard to understand why that rationale would not also apply to more severe injuries. There is also a suggestion that the Minister, in his second reading speech relating to the Motor Accident Injuries Bill 2017

[64] Law and Justice Review, *Hearing Transcript*, 25 May 2021, page 38 (Mr Stone).

[65] SIRA, *Standing Committee on Law and Justice: 2020 Review of the Compulsory Third Party Insurance Scheme: Pre-hearing questions for SIRA*, pages 7, 8.

when it was in Parliament, explained that the intention of the waiting period is to deter fraud.[66] However, in the relevant passage of that speech, the Minister was referring to the provisions of Part 4 of the Act,[67] and these do not include the 20-month waiting period. The relevant provision is in Part 6 of the Act.

We recognise that there is evidence that claims for lump-sum compensation can be associated with poor health outcomes.[68] What is not clear to us, though, is that this is true for the injured persons who would be most likely to be discouraged by the 20-month waiting period from making a claim for damages. Presumably, those potential claimants are the persons who by 20 months have left the Scheme and moved on. These are the less severe cases of injury where the injured person has been through a statutory benefits claim, maximised their recovery, and returned to work and other activities before claiming damages for past economic loss only. The upshot of this is that, from the standpoint of supporting injured persons to achieve the best health-related outcomes and access the financial support that the Scheme provides, the current 20-month waiting period does not seem to have any solid, rational foundation and should be removed.

3.2.5 The 5% discount rate on future economic loss

Section 4.9 of the Act has the effect that an award of damages in respect of lost future earnings or financial support is to be qualified by the application of a discount rate, being the rate set by the Regulations or, if there is no such rate, 5% per annum.[69] Currently, there is no rate set by the Regulations and the default rate of 5% applies.

The purpose of applying a discount rate was explained in the *Final Report of the 2002 Review of the Law of Negligence* (**Ipp Report**):[70]

> *When a court awards a lump sum for future economic loss or future expenses that will be suffered or incurred periodically, it assumes that the plaintiff will invest the lump sum and receive a stream of income from the investment. As a result, to ensure that the plaintiff does not receive too much, the sum of the expected total future losses and expenses needs to be reduced by using a 'discount rate' in order to calculate its present value. That is, the court arrives at a figure for future economic loss that takes into account the capacity of the plaintiff to invest the lump sum and generate income thereby. The discount rate is a technical mechanism used to arrive at the present value of compensation for future losses and expenses.*

The common law rate determined by the High Court in 1981 is 3%. In 2002, the Ipp Report concluded that:[71]

> *using a discount rate higher than can reasonably be justified … would be an unfair and entirely arbitrary way of reducing the total damages bill.*

At that time, the Australian Government Actuary informed the review that led to the Ipp Report that a realistic after-tax discount rate would be from 2-4%.

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[66] SIRA, *SIRA's answers to questions taken on notice at the Law and Justice Committee's 2020 Review of the Compulsory Third Party Insurance and Lifetime Care and Support schemes (CTP and LTCS) hearing – 26 May 2021*, page 13.

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

[68] SIRA, *Minor Injury Review*, pages 9, 26.

[69] Section 4.9(2) of the Act.

[70] D Ipp, P Cane, D Sheldon and I Macintosh, *Review of the Law of Negligence: Final Report*, September 2002, page 208.

[71] Ibid, page 210.

In 2005, the report of the New South Wales Parliament's General Purpose Standing Committee No. 1, *Personal Injury Compensation Legislation* recommended that the 1999 Act be amended to reduce the discount rate to 3%.[72]

It might be thought that, even if the discount rate under the Act is higher than necessary to arrive at the present value of compensation for future economic loss, it is nevertheless consistent with the absence of a compensation objective in the Act and could legitimately advance the objective of keeping premiums for CTP policies affordable. However, in our view this proposition is not compelling.

First, section 4.9(1) of the Act states the purpose of the discount rate as follows: "*the **present value of the future economic loss** is to be qualified by adopting the prescribed discount rate*" (emphasis added). The 'prescribed discount rate' is defined in section 4.9(2): "*(a) a discount rate of the percentage prescribed by the regulations, or (b) if no percentage is so prescribed – a discount rate of 5%.*"

These provisions contemplate that the Regulations will prescribe the discount rate, and provide a default rate that otherwise applies. The provisions would probably not authorise the making of a regulation which was aimed at any purpose other than actually qualifying the present value of future loss. Arguably it is contrary to the intention of the Act to keep in place a discount rate which exceeds – or is less than – the discount rate necessary to give the present value of future economic loss.

Second, while the Act does not aim to give full compensation, it aims to provide ongoing financial support. There is a complex framework to limit expenditure on claims for financial support within the Scheme, whilst still advancing the financial support objective. It is designed to ensure that financial support is provided where it is needed, and limit financial support where that can be justified having regard to the cohort of affected claimants. The use of "*an unfair and entirely arbitrary way of reducing the total damages bill*" is inconsistent both with the objective of giving ongoing financial support and the design of the Scheme to achieve that objective. An award of damages for future economic loss that is arbitrarily reduced may result in financial support either running out while it is still needed, or providing support over the full period but to a degree which is less than needed.

Third, the effect of a discount rate higher than the appropriate level is contrary to one of the original aims of the 2017 reforms, which was to ensure that a higher proportion of benefits went to the most seriously injured. The injured persons worst affected by an inappropriate discount rate are those who are most seriously injured, and amongst those persons the worst affected are catastrophically injured children.

For example, damages calculated over 40 years are 25% less using a 5% discount rate compared to a 3% discount rate. The total proportionate reduction to an award of damages declines as the period shortens over which the future loss of income has to be calculated.

In 2005, the government of the day did not support the recommendation by the General Purpose Standing Committee No. 1 to reduce the discount rate in the 1999 Scheme to 3%.[73] The rationale given for doing so relied on the existence of the Lifetime Care and Support Scheme (**LTCS Scheme**); the scheme under the *Motor Accidents (Lifetime Care and Support) Act 2006* for the lifetime treatment and care of persons catastrophically injured in motor accidents. The position was stated as follows:[74]

> *In catastrophic injury claims, damages for future care and treatment are the major component of the award. With the establishment of the LTCS scheme, the effect of the discount rate on lump sum awards for the severely injured will be considerably less significant. In particular, the replacement of a lump sum for future care by the LTCS scheme alleviates concerns presented to the Committee that that the lump sum award will run out earlier than intended. The provision of lifetime care and support also addresses the Committee's*

[72] General Purpose Standing Committee No. 1, *Personal Injury Compensation Legislation*, December 2005, page 149.

[73] New South Wales Government, *Response to the Legislative Council General Purpose Standing Committee No. 1 Inquiry Report into Personal Injury Compensation Legislation*, 8 June 2006, page 16.

[74] Ibid, page 17.

concern that "the pool of capital to fund damages should be targeted at the severally or catastrophically injured".

The difficulty that we have with this position is that it has no regard for persons who do not participate in the LTCS Scheme and, for those who do, it appears not to recognise that catastrophically injured persons have needs other than just treatment and care.

The LTCS Scheme only provides support for *treatment and care* made necessary by the person's injuries. Damages in respect of lost income provide support for all of the *other* aspects of the injured person's life, where the injuries were caused by the fault of another person. A young person who is catastrophically injured will have the same non-health related needs and aspirations as any other person. These will go beyond the basic needs of housing and subsistence, for which an income is certainly necessary, to common aspirations such as to own a home, to start and raise a family, to travel, and to have the opportunity to make a meaningful contribution to community. A young person's opportunity to realise such aspirations may be taken away from them by injuries that prevent or constrain income-producing work. Where that is the case, an award of damages is the mechanism that the law provides by which that opportunity may be restored.

We recommend that the Government consider the making of a regulation which properly qualifies the present value of future economic loss, consistently with the intention of the legislation. This would require consultation with the Scheme Actuary to understand the effect of any change on the cost of the Scheme. If there is a need for the Scheme to have a mechanism to reduce damages awards to ensure the continued affordability of CTP premiums, then in our view an arbitrary discount applied to all awards of future economic loss is not an appropriate mechanism, having regard to the terms of Objective (b) of the Act and the design of the framework to achieve Objective (b).

Recommendation 18

The Minister consider the making of a regulation under section 4.9(2)(a) of the Act to specify a discount rate lower than 5% and which properly qualifies the present value of future economic loss.

***Rationale**: A higher discount rate has the most significant impact on financial support for the most severely injured persons – particularly those who are younger.*

3.3 Objective (c) – Compulsory CTP insurance

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

The Review sought and received feedback on the validity of Objective (c). Stakeholders support retaining this objective, and did not propose any changes to the current framework for securing it.

The conclusion from Deloitte's analysis in Part 4 of this report is that the Scheme is meeting Objective (c).

We did receive some feedback that assessment of this Objective should include assessment of compliance with the requirement to hold CTP insurance, on the basis that claims against the Nominal Defendant (the 'relevant insurer' for uninsured vehicles) increase Scheme costs for motorists who comply with the obligation to purchase a CTP policy. This is a matter of Scheme implementation and is considered in Part 4.

We do not make any recommendation relating to the framework for Objective (c).

3.4 Objective (d) – Affordability

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.

3.4.1 Introduction

Objective (d) is to keep CTP 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; and
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;[75]
- risk equalisation arrangements under section 2.24 of the Act; and
- SIRA's power directly to adjust profits that are realised.[76]

The 'minor injury' framework includes the following measures to limit benefits to persons with only 'minor injuries':

- access to statutory benefits for treatment is limited after 26 weeks by a more restrictive test than the 'reasonable and necessary' test that otherwise applies;
- weekly payments are not available after 26 weeks; and
- there is no entitlement to an award of damages (i.e. even for those injured through the fault of another driver).

Since the 'minor injury' framework is generally intended to apply to persons who are expected to recover from their injuries within the period when statutory benefits are available, the Act's primary way of limiting benefits available to persons with only 'minor injuries' to keep CTP premiums affordable is the third measure – the removal of any entitlement to an award of damages.

We discuss the 'minor injury' framework later in this report.

We received detailed submissions from a research economist, Dr Richard Tooth, relating to the objective of affordability, including that it is a commonly stated objective but lacks any clear, necessary meaning.[77]

The Scheme aims to achieve a high degree of consistency in the price motorists have to pay for a CTP policy, regardless of characteristics of the owner in terms of what, where, when and how they drive. Deloitte analyse 'affordability' through a comparison of weekly average earnings with the average cost to motorists of a CTP policy. In our view, this simple metric is consistent with the Scheme's concept of 'affordability'.

Dr Tooth submits that this concept of 'affordability' – where CTP premiums should be reasonably within the purchasing power of all motorists, irrespective of driving-related decisions – drives much of the complexity in

[75] Division 2.3 of the Act.

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

[77] R Tooth, *Submission to Review*, page 6.

the aspects of the Scheme that regulate premiums, profits, competition and innovation. Dr Tooth goes on to say:[78]

> *Most significantly, the regulations that stem from the interpretation of affordability remove the incentive and ability for insurers to proactively reduce the risk of death and injury from motor vehicles. As a result, lives have been lost and ruined and people have paid more for their insurance.*

We return to this issue in our discussion on Objective (e).

3.4.2 Insurer profits: premium regulation

The Act provides that insurance premiums for CTP policies must be charged in accordance with Division 2.3 of the Act.[79] 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.[80] 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.[81]

Insurers are required to disclose to SIRA the assumed profit margin on which a filed premium is based, as well as the actuarial basis for its calculation.[82] Under clause 1.59 of the Guidelines, the maximum assumed profit margin allowed when determining premiums is 8% of the proposed average gross premium (excluding levies and GST), 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 an expected 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.

In our Discussion Paper, we asked stakeholders whether 8% exceeds, or does not exceed, the amount of profit that is sufficient to underwrite the relevant risk.[83] Suncorp submitted that 8% is an adequate margin to underwrite the risk.[84] The ICA submitted that consideration should be given to conducting an independent review to assess whether 8% remains appropriate given capital requirements and emerging claims experience.[85] We make no recommendation in this regard. We assume that the ICA may commission such an independent review if considered appropriate and engage with SIRA, depending on the outcome of the review.

The ICA also submitted that insurers recommend establishment of an annual review of the policy administration or claims handling expense assumptions that they are allowed to factor into their filed premiums. The ICA argued that, by "ensuring the expenses allowable are reflective of true operational cost, insurers can continue to drive optimal health outcomes for claimants and ensure premiums remain

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[78] Ibid, page 7.

[79] Sections 2.19, 2.20 of the Act.

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

[81] Section 2.22 of the Act.

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

[83] Discussion Paper, Question 41.

[84] Suncorp, *Submission to Review*, page 9.

[85] ICA, *Submission to Review*, page 16.

affordable."[86] We consider that this is an appropriate matter for the ICA to take up directly with SIRA in consultation with the Scheme Actuary.

3.4.3 Insurer profits: risk equalisation

One effect of ensuring that CTP premiums cost much the same for drivers across all demographic characteristics, is that the premiums paid by low-risk cohorts 'cross-subsidise' the premiums paid by high-risk cohorts. Absent cross-subsidisation, premiums paid by low-risk cohorts would be lower, and premiums paid by high-risk cohorts would be higher. The premium regulation framework in the Scheme evens them up. This affects the price that people pay for CTP policies, but it does not affect the total amount of premium dollars collected across the State in a given year.

While the Scheme as a whole is balanced in terms of cross-subsidisation, issues can arise in terms of CTP market behaviour and insurer profits if individual insurers' own portfolios are allowed to become unbalanced. In principle, an insurer could seek to maximise profits by having a portfolio of CTP policies that comprises an imbalance between vehicle owners from low-risk and high-risk cohorts.

The Act seeks to address this. It makes provision for a risk equalisation mechanism (**REM**) to achieve "an appropriate balance between the premium income of an insurer and the risk profile" of policies issued by the insurer.[87] 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.[88]

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 cost of claims and for the allocation and transfer of those costs among insurers.[89] 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.[90]

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 intended effect of this is to ensure that, within each insurer's own portfolio of CTP policies, there is an appropriate balance of the cross-subsidies between low-risk and high-risk CTP policies.[91]

SIRA published a review of the REM in July 2019, titled *CTP Premium & Market Supervision: Review of the Risk Equalisation Mechanism (REM)* (**REM Review**). 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".[92]

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[86] ICA, *Submission to Review*, page 15.

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

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

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

[90] SIRA, *REM Review*, page 6.

[91] Ibid, page 5.

[92] Ibid, page 12.

In recent submissions to the Law and Justice Review, SIRA stated that it "is now wholly satisfied that the objectives of the Risk Equalisation Mechanism (REM) are being met."[93]

In the REM Review, SIRA stated that it would "report on any changes made to the REM in the statutory review of the scheme which will commence in December 2020" (i.e. in this Review).[94] We have not been briefed about any changes that have been made to the REM since the REM Review. We received no submissions from stakeholders for changes to the REM,[95] and we make no recommendations relating to the REM.

3.4.4 Insurer profits: adjustment of realised underwriting profits

Section 2.25 of the Act gives SIRA the power to adjust insurer profits directly by requiring adjustments to past or future premiums, or adjustments to Fund levies either to fund payments to insurers (to increase profits) or to be funded by payments from insurers (to decrease profits).[96]

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 the outcome of 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 has to make this comparison annually.

Adjustments of profit under section 2.25 would require SIRA to adjust each insurer's underwriting profit to match the estimate on which the insurer based its premiums (in practice, approximately 8%).

The Guidelines may make 'special arrangements' for adjusting insurer profit under section 2.25.[97] 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 *Motor Accident Guidelines: Transitional Excess Profits and Transitional Excess Losses 2019* (**TEPL Guidelines**). These provisions require annual preparation of a report by the appointed 'Scheme Actuary' into the industry-wide underwriting profit margin for concluded 'Accident Periods' (except the most recently concluded Accident Period at any given time). If the industry underwriting profit margin for a given Accident Period is outside the range of 'reasonable profit'[98] set by SIRA (currently 3%–10% of premium for the Accident Period[99]), then SIRA may proceed to a further assessment of industry-wide underwriting profit margin taking into account individual insurer contributions to aggregate underwriting 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

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[93] SIRA, *Standing Committee on Law and Justice 2020 Review of the Compulsory Third Party Insurance Scheme: Pre-hearing questions for SIRA*, page 4.

[94] SIRA, *REM Review*, page 4.

[95] We did receive submissions to the effect that there should be no regulation of pricing, and that this should include removal of mechanisms such as the REM.

[96] 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.

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

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

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

this further assessment, the industry-wide underwriting profit is below 3% or above 10%, then SIRA may make adjustments to insurer profits.

For industry-wide underwriting profit above 10%, adjustments would involve SIRA requiring insurers whose individual underwriting profit is above 8% to pay money into the SIRA Fund in proportion to their contribution to the excess industry-wide underwriting profit above 8% (thus reducing their respective underwriting profit margins, but not below 8% for any individual insurer). SIRA would then use this money to reduce the Fund levies payable by motorists for CTP policies, thus reducing 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 Fund by insurers.

If SIRA makes a complete adjustment of underwriting profit under the TEPL Guidelines for premiums earned in a given Accident Period, then the industry-wide average underwriting profit margin in respect of that premium will be 10%.[100] However, individual insurer profit margins after adjustment will vary around that mean.

Importantly, given the long-tail nature of CTP insurance, insurer underwriting 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 underwriting 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:[101]

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

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

In the TEPL analyses undertaken in 2020, there were insufficient claim payments to satisfy the above criteria 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 submissions to the Law and Justice Review earlier this year, 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.[102] We are not aware of the progress in respect of the TEPL process for those Accident Periods.

Given that the Scheme is still in such an early stage that there has been insufficient claim development to enable a complete activation of the TEPL Guidelines to assess whether insurer profits should be adjusted, our view is that it is too early to review the efficacy of the TEPL mechanism.

If insurer profits are 'clawed back' under the TEPL Guidelines, the current legislation requires that the funds be used to reduce the cost of CTP premiums, either by requiring insurers to charge lower premiums or reducing the Fund levies included in the price of CTP policies. In our Discussion Paper, we noted that an alternative that has been suggested is to use the excessive profits to fund road-related initiatives.[103] In feedback to the Review, there was little support for this alternative and we do not recommend any change to the Act in this regard.

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[100] Ignoring any additional profit retained by an insurer by way of 'Innovation Support'.

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

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

[103] Discussion Paper, Question 43.

Comparison of the two mechanisms for adjustment of insurer profit

The TEPL 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. For example, unlike the TEPL provisions, section 2.25:

- provides only for an 'all or nothing' adjustment of insurer profits, allowing SIRA no flexibility to adjust profits less than all the way to the filed (i.e. originally assumed) level of underwriting profit;
- focuses on adjustments to the profit margins of individual insurers rather than industry average underwriting profit margins;
- does not provide for assessment or adjustment of underwriting profit by reference to a range of reasonable underwriting profit. Rather, the underwriting profit of each insurer is assessed against its own filed underwriting profit margin; and
- makes no provision allowing SIRA to take account of innovations by insurers in the assessment of profit margins.

One effect of the provisions of section 2.25 is that profit adjustments under that section will not only *adjust* the underwriting profit margins of affected insurers but also *equalise* them (assuming all have based their premiums on assumed profit margins of 8%). In our Discussion Paper, we asked stakeholders for their views as to whether section 2.25 of the Act should be amended to align more closely with the way that insurer profits are regulated under Part 2 of Schedule 4 to the Act.[104] Suncorp, and the ICA on behalf of the CTP insurers generally, said that section 2.25 should be amended to align with the TEPL provisions in Part 2 of Schedule 4 to the Act.

We agree that section 2.25 should be amended. In addition to enabling SIRA, in the Guidelines, to create a mechanism and process under section 2.25 that aligns more closely with those of the TEPL Guidelines, amendments to section 2.25 should consider whether its provisions can be drafted with greater clarity as to the framework for profit adjustment relating to premiums collected after the transition period, when the TEPL Guidelines will no longer apply.

Recommendation 19

The legislature consider amending section 2.25 of the Act to align with Part 2 of Schedule 4 to the Act, to enable Guidelines made under section 2.25 to adopt the mechanism and procedure for profit adjustment in place under the TEPL Guidelines.

***Rationale**: It is important that the mechanism to adjust insurer profits is clearly drafted and works appropriately.*

Operation of TEPL in relation to the transition period

Broadly speaking, the TEPL provisions under Part 2 of Schedule 4 to the Act are intended to regulate insurers' profits on CTP policies issued during the 'transition period', which is the period after 1 December 2017 and ending on a date to be prescribed by regulation.[105]

The underwriting profit derived from a given period will not be known with a high degree of certainty until years after the premium has been collected. Insurers' liabilities under the Scheme have a 'long-tail' nature. Claim payments relating to motor accidents in a given period will continue to be made for five years or more

[104] Discussion Paper, Question 44.

[105] Clause 2(1) of Part 2 of Schedule 4 to the Act.

after that period, and insurers price their premiums for a given period based on expected claim costs in respect of accidents occurring in that period.

For this reason, in order to carry out the intention of the TEPL provisions, SIRA may need to exercise its powers *after* the transition period to adjust profits derived from CTP policies sold *during* the transition period.

In the course of our Review, SIRA asked us to consider this aspect of the TEPL provisions, expressing its concern as follows:[106]

> *The TEPL mechanism allows SIRA to avoid or minimise transitional excess profits and transitional excess losses. SIRA anticipates that it would take a staged approach to recovering excess profits or losses, progressively across each accident year. This means that the TEPL assessment on all transitional years will not be completed prior to the end of the transition period. It is critical that SIRA can continue to recover excess profits or losses related to all transitional years once the transitional period has ended. An examination of the legislative provisions in this regard should form part of the review.*

We express no view about whether the provisions of Part 2 of Schedule 4 to the Act would prevent SIRA from recovering excess profits or losses related to all transitional years when the transitional period has ended. However, it is certainly the case that Part 2 of Schedule 4 does not include any provision that states clearly whether or not SIRA may do so. Moreover, we agree that, for the TEPL mechanism to work as intended, SIRA must be able to deploy the mechanism after the transition period in relation to profit derived from CTP policies sold during the transition period. Therefore, we recommend that Part 2 of Schedule 4 be amended to put the position beyond doubt.

Recommendation 20

The legislature consider amending clause 2 of Part 2 of Schedule 4 to the Act, to provide expressly that SIRA may exercise a power under clause 2 relating to third-party policies in force during the transition period, either during or after the transition period.

***Rationale**: It is important that the mechanism to adjust insurer profits is clearly drafted and works appropriately.*

[106] SIRA, Letter to Clayton Utz and Deloitte dated 9 June 2021.

3.5 Objective (e) – Premium setting and SIRA's role

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.

3.5.1 Introduction

Objective (e) comprises two related aspects:

1. to promote competition and innovation in the setting of premiums; and
2. to provide SIRA with a role to ensure the sustainability and affordability of the Scheme and fair market practices.

We consider these two aspects of Objective (e) separately below, in terms of the feedback we received on the design to achieve them. We then include a discussion about the content of Objective (e) itself.

3.5.2 Competition and innovation in the setting of premiums

Efficacy of the framework to promote competition and innovation in the setting of premiums

Deloitte's analysis indicates that, in its implementation, the framework is broadly supportive of competition and innovation in the setting of premiums.

The insurers suggest that competition is resulting in a reduction in premiums. The ICA observed that there has been a 28% reduction in premiums compared to the 1999 Scheme:[107]

> *which suggest*[s] *that the current regulatory mechanisms are promoting competition. SIRA allows risk-based pricing, within the regulated limits, to keep premiums competitive and fair for all. The ability for real time transactions has not only accelerated online sales, but also promoted greater reach, competition and pricing.*

There is, however, a question as to whether the reduction in premiums compared to the 1999 scheme is more a result of benefit changes rather than increased competition.

Suncorp wrote:[108]

> *We are witnessing greater competition and innovation in the setting of premiums for third-party policies*[.]
>
> …
>
> *Since the enactment of the new NSW CTP Scheme, CTP insurers have been increasingly competing on price. This is evident through insurers making more frequent price changes and a significant reduction in the average CTP premium base rate.*
>
> *In the 43 months since the reform was introduced there have been 33% more price changes than the comparable period prior to reform. This equates to a price change approximately every 1.5 months, compared to every two months prior to reform.*
>
> (Citations omitted.)

[107] ICA, *Submission to Review*, page 18.

[108] Suncorp, *Submission to Review*, page 9.

In relation to price changes, Suncorp advocates for simplification of the premium filing process, including the 'interim' process for relatively small price changes which Suncorp says is similar to the full process in terms of process and timeframes.[109] This is the subject of Deloitte's Recommendation 24.

Also related to premium filing was a submission by the Motorcycle Council of NSW, stating that there are 25 different premium classes for motorcycles and that it is "keen to discuss with SIRA how the scheme could be made more efficient by possibly combining classes".[110]

Suncorp also pointed to a range of non-price areas of competition and innovation in the Scheme which it says benefit customers and injured persons.[111]

The ICA submitted that more could be done to harness the benefits of competition and innovation in the Scheme:[112]

> *Pricing competition in the Scheme is fettered by design and operation. Pricing regulation, risk equalisation and the excess profit and excess loss mechanism place considerable constraint upon competition in premium setting and limit the benefits that can flow to motorists.*

The ICA says that this means competition and innovation in other areas of the Scheme need greater recognition, and wrote that the insurers "would be pleased to engage with SIRA on possible approaches to promoting greater competition and innovation in the Scheme to benefit both motorists and claimants."[113] We assume that the ICA will approach SIRA for this engagement.

'Innovation Support'

There is provision for insurers to have a proportion of profit up to 3% sit outside the reach of the profit adjustment mechanism, if allowed by SIRA under the 'Innovation Support' provisions in clause 8 of the TEPL Guidelines. SIRA may grant this Innovation Support to an insurer in respect of an innovation implemented by the insurer to promote the objects of the Act.[114] There is a detailed process in clause 8 of the TEPL Guidelines for applications to SIRA for Innovation Support, SIRA's assessment, preliminary approval and final approval of proposed innovations, and SIRA's post-approval assessment of implementation.

The insurers consider that this aspect of the TEPL Guidelines "involves an overly cumbersome administrative process to utilise which could be improved with simplification and streamlining."[115]

However, we have not received any specific proposal for amendments to clause 8 of the TEPL Guidelines, and we are not aware of the particular concerns that may have arisen as SIRA and the insurers proceed through the Innovation Support process. Therefore, we are not in a position to make any recommendations for changes to this aspect of the TEPL Guidelines. Again, we assume that the insurers, through the ICA, will engage directly with SIRA in relation to the Innovation Support provisions of the TEPL Guidelines if changes are considered necessary.

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[109] Suncorp, *Submission to Review*, page 10.

[110] MCC, *Submission to Review*, page 4.

[111] Suncorp, *Submission to Review*, page 10.

[112] ICA, *Submission to Review*, page 18.

[113] Ibid, page 19.

[114] Clause 2(4A) of Part 2 of Schedule 4 to the Act.

[115] ICA, *Submission to Review*, page 19.

Point to point industry

Special Guidelines apply to the determination of CTP premiums for taxis and hire vehicles.[116] Earlier this year SIRA consulted on new Point to Point Guidelines intended to commence by 1 December 2021.[117] 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."[118] 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.[119]

In submissions to the Law and Justice Review, the NSW Taxi Council pointed out that taxi operators currently have to pay more for CTP insurance up-front than rideshare operators and, unlike rideshare operators, do not have the ability to pass on the 'pay as you go' distance-travelled part of the premium to customers.[120]

Ultimately, the NSW Taxi Council advocates for change such that there be "no commercial disparities between Taxis and Rideshare".[121] The NSW Taxi Council is concerned that the current reform agenda for the point to point industry will not address commercial disparities for small business operators in the industry.[122]

In our Discussion Paper, we asked stakeholders whether there are commercial disparities (particularly for small business operators) in the point to point industry.[123] We also asked stakeholders whether, if there are such commercial disparities, the current reforms to determination of CTP premiums for taxis and hire vehicles address them. We also asked whether there are innovations in premium setting that could further address any disparities.[124] The ICA responded by saying that "many significant and relevant matters relating to the point-to-point industry have only recently been resolved and are yet to be implemented" and it is too early to respond.[125] Suncorp stated that it supports uniformity in the determination of premiums in the point to point industry, and that this "will be achieved when the whole industry moves towards a pay per use model."[126]

Apart from the NSW Taxi Council's submission to the Law and Justice Review and insurers' submissions to us, we received no other submissions directly responding to our questions about the point to point industry. We assume that SIRA is including consideration of the NSW Taxi Council's submission to the Law and Justice Review, in its consultation on the Point to Point Guidelines.

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

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

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

[119] Ibid, page 4.

[120] NSW Taxi Council, *Submission to Law and Justice Review*, page 11.

[121] Ibid, page 16.

[122] Law and Justice Review, *Hearing Transcript*, 25 May 2021, page 17 (Mr Rogers).

[123] Discussion Paper, Question 53.

[124] Ibid, Question 54.

[125] ICA, *Submission to Review*, page 19.

[126] Suncorp, *Submission to Review*, page 11.

3.5.3 SIRA's role

In our Discussion Paper, we asked stakeholders for feedback as to whether the framework which defines SIRA's role in relation to sustainability, affordability and fair market practices is adequate and appropriate to enable SIRA to take steps to ensure that these aims are achieved.[127]

On behalf of the insurers, the ICA observed that the framework includes empowering SIRA to:[128]

- issue guidelines regulating the pricing and distribution of policies and handling of claims;
- issue guidelines encouraging innovation and competition;
- prosecute fraud in relation to the Scheme; and
- collect, use and provide data on Scheme performance.

The ICA submitted that, "[g]iven the stage of development of the Scheme with somewhat limited experience with SIRA's exercise of the above noted powers, it is not possible to definitively respond to this question."[129]

We did not receive other submissions directly addressing this question.

3.5.4 Content of Objective (e)

We received some feedback to the effect that Objective (e) should be expanded.

On behalf of the insurers, the ICA submitted:[130]

> *Competition and innovation are recognised as important to the Scheme as they are associated with producing better customer outcomes and experiences. Insurers consider the Scheme and its 'customers' (policy holders and claimants) would be better served by revising the objective to promote competition and innovation in more areas not just premium setting.*

Suncorp, submitted that:[131]

> *competition and innovation should not be limited to the setting of premiums but extended to other areas of the Scheme more generally.*

Dr Tooth submitted that Objective (e):[132]

> *is a valid objective to promote competition and innovation. It is unclear why the clause 'in the setting of premiums for third-party policies' is required. A more general clause would be appropriate such as 'in the pricing and supply of third-party insurance.' This would reflect the broader role of insurers in managing accident risk.*

Despite these submissions, we are not recommending that this aspect of Objective (e) be expanded. We agree that competition and innovation in all aspects of service delivery in the Scheme is to be encouraged. However, in our view an expansion of Objective (e) would have a clearer justification if it were established that such an amendment could actually facilitate competition and innovation in other aspects of the Scheme.

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[127] Discussion Paper, Question 55.

[128] ICA, *Submission to Review*, page 20.

[129] Ibid.

[130] Ibid, page 18.

[131] Suncorp, *Submission to Review*, page 9.

[132] R Tooth, *Submission to Review*, page 14.

It is relevant to observe that the Act already has Objectives relating to the support of injured persons, the early resolution of claims, and the quick, cost effective and just resolution of disputes. Competition and innovation in relation to these matters is therefore already supported by the Objectives. One element that seems clearly to be missing from the Objectives is to reduce the frequency and seriousness of injuries resulting from motor accidents, and later in this report we recommend the introduction of an objective relating to road safety. One of our reasons for doing so is to help ensure that innovations aimed to advance that objective can be supported by the Act and those who administer and oversee the Scheme.

As we see it, the reference to competition and innovation *in the setting of premiums* in Objective (e) recognises that the Scheme places significant restrictions on the setting of premiums for CTP policies, and these restrictions are capable of restricting competition and innovation. The Objective aims to balance this aspect of the premium framework with an encouragement to promote competition and innovation in the setting of premiums. It is relevant to observe that this can affect implementation of the Scheme, by virtue of sub-sections (4) and (5) in section 1.3 of the Act:

> (4) In the interpretation of a provision of this Act or the regulations, a construction that would promote the objects of this Act or the provision is to be preferred to a construction that would not promote those objects.
>
> (5) In the exercise of a discretion conferred by a provision of this Act or the regulations, the person exercising the discretion must do so in the way that would best promote the objects of this Act or of the provision concerned.

Absent restrictions on setting premiums, insurers are natural competitors and innovators. Objective (e) recognises both that the premium framework affects this aspect of insurer behaviour, and that the custodians of the Scheme must nevertheless work to achieve competition and innovation within that framework, because that is in the interests of the motorists of New South Wales. Objective (e) also recognises and validates SIRA's role in balancing – or harmonising – competition, innovation, affordability and sustainability, and fair market practices in the setting of CTP premiums and the sale of CTP policies.

Rate regulation

The Act is built upon an assumption that regulation of CTP premiums (i.e. regulation of what insurers may charge motorists for CTP insurance policies) is necessary to ensure that CTP insurance is 'affordable'. Insurers are limited in their ability to price CTP premiums according to risk having regard to the characteristics of the policyholder. The outcome is that the size of the premium pool in the Scheme as a whole is that which, collectively, the insurers assess is necessary to cover the risks and run their businesses, but there is cross-subsidisation between less risky and more risky cohorts of motorist. The REM seeks to ensure that cross-subsidisation within *each insurer's portfolio* of CTP policies is appropriate (and not just across the CTP policies in the Scheme as a whole).

Arguably, there is no necessary meaning of the concept of 'affordability' in the context of CTP insurance. Deloitte measure implementation of the 'affordability' objective by reference to average weekly earnings, and this is appropriate to measure implementation because it is consistent with the concept of affordability that is built into the Scheme. Deloitte's conclusion is that the framework is achieving 'affordability' in this way – CTP premiums should be within the capacity of most motorists to pay, even on a relatively modest income.

We observe that this concept of 'affordability' means that anybody with a driver licence should be able to afford a CTP policy with whatever registrable car they choose.

This is a justifiable aim, but two points are worth bearing in mind. First, the aim arguably comes at the cost of a degree of road safety, and therefore at a cost that could be measured in injuries, lives, and financial cost to the Scheme.[133] In principle, a greater degree of flexibility in the pricing and charging of CTP policies could be used to steer safer driving decisions including decisions such as what, when, where and how to drive.

[133] R Tooth, *Submission to Review*, page 1.

Second, according to the submission of Dr Richard Tooth, "*there is a body of international evidence which finds that stringent rate regulation leads to worse outcomes including higher premiums.*"[134] Dr Tooth also made a submission as follows:[135]

> *In the interests of encouraging competition, innovation, and affordability (lower average premiums) as well as safety outcomes, a number of changes are required. It is desirable that:*
>
> - *insurers can seamlessly bundle CTP and motor vehicle insurance into a single product*
> - *insurers' incentives to prevent road crashes that cause death and injury align with that of society*
> - *there are no barriers imposed by the scheme that prevent insurers from pricing for, and managing, risk (with minor qualification)*
> - *regulatory barriers to entry and exit and minimised.*
>
> *Achieving these goals would require substantial changes to the Act, Regulations and Guidelines. These include:*
>
> - *removal of unnecessary licence conditions*
> - *removal of rate regulations (including bonus/malus) and the risk equalisation mechanism*
> - *removal of premium filing requirements*
> - *removal of the profit normalisation measures.*

We share Dr Tooth's view that the question as to what mechanisms and scheme design are most effective to achieve affordability are factual questions that require research and analysis, including on an ongoing basis. We also agree with Dr Tooth that insurers can, in principle, have an important role to play in managing the risks they insure and in the case of CTP policies this means the frequency and severity of road crashes and the injuries that result from them. To the extent that the objectives of affordability and road safety can be advanced in tandem, then it is important that this is kept under consideration by SIRA, which has the function of advising the Minister as to the administration, efficiency and effectiveness of the Scheme.

Recommendation 21

SIRA undertake a consultation to report on any barriers in the Scheme to innovation in the setting of premiums and other aspects of the conduct of CTP insurance business, and the extent and manner in which removal of those barriers would affect:

(a) affordability; and

(b) the flexibility and incentive for insurers to innovate in ways that advance the objectives of the Act and encourage safer driving decisions.

***Rationale**: The motorists of New South Wales will benefit from innovation in CTP business to achieve the objectives of the Act and encourage road safety. This should be the subject of ongoing work to understand how to support insurers in their efforts to innovate.*

[134] Ibid, page 13.

[135] Ibid, page 15.

3.6 Objective (f) – Deterring fraud

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

There are several aspects of the Scheme that are directed at deterring fraud and 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; and
- certain claims handling provisions in the Guidelines and in Part 5, Division 4 of the Regulations.

The 'minor injury' framework is intended (in part) to deter fraud and exaggeration in claims because it reduces the scope to make small claims for lump-sum compensation for soft tissue and relatively minor psychological injuries.[136] SIRA considers that the 'minor injury' framework "has successfully reduced the ability for people to abuse the system."[137]

We sought feedback from stakeholders on the extent to which the Scheme framework has been effective in deterring fraud in the Scheme, on whether additional elements should be introduced into the framework, and on whether obligations on insurers should be more prescriptive.[138]

The Review received feedback on these issues from several stakeholders, particularly from insurers and a law firm, on issues associated with the Scheme's framework.[139]

The law firm that provided feedback – being a stakeholder likely to be in fairly regular contact with issues associated with fraud and exaggeration in the Scheme – made detailed observations on the framework relating to fraud. Essentially, in this firm's submission, while there is a clear obligation on insurers to deter and prevent fraudulent claims,[140] and a clear power in SIRA to investigate claims to detect and prosecute fraudulent claims,[141] there is little guidance as to how insurers may carry out that obligation or how SIRA will exercise its power, and some aspects of the framework are under-developed:[142]

> *The current scheme, including the provisions in the Act are clear in this objective and obligations on the insurer and do provide for penalties and remedies for deterrence of the making of fraudulent claims and false and misleading statements.*
>
> *However, the current scheme does not provide any proper framework or clarity as to how the objectives and provisions are to be implemented. There is no reference to the investigative powers of insurers in the Regulations or the Motor Accident Guidelines and no clear power to cease statutory payments should fraud/false and misleading claim be alleged. Further, there is no clear path to implementation of any of the penalties allowed for in the Act. It would therefore seem that … these provisions remain significantly underutilised, increasing the opportunity for increased fraudulent activity…*

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

[137] SIRA, *Submission to Law and Justice Review*, page 18.

[138] Discussion Paper, Questions 60-62.

[139] See Appendix A to this report.

[140] Section 6.39 of the Act.

[141] Section 10.1(1)(f) of the Act.

[142] (Confidential), *Submission to Review*.

Further, it is noted that a number of the objects and provisions of the Act mirror that of [the legislation governing the 1999 Scheme]. However, it is noted that the new scheme introduced significant new difficulties in the deterrence of fraud and false/misleading claims in circumstances where statutory payments are made early and often without proper powers to investigate a claim and where the regulated cost structure applied to insurers stymies the ability to engage legal representation to properly investigate and defend fraudulent claims.

It is further noted that the piecemeal nature of the dispute process in the statutory benefits space makes it difficult to obtain and review the evidence in the claim overall. For example, a liability dispute may be lodged and assessed without access to the claimant's medical records which may show a history of similar injury relevant to the assessment of the claimant and the claimant's credibility but which may not be considered at all in a "wholly or mostly at fault" dispute. It is suggested that allowing Common Law Damages claims to be brought at an earlier stage may encourage a more holistic investigation of the claimant which would, in turn, help in the deterrence of fraud in the statutory benefits space.

…

[G]uidance is required in relation to the insurer's ability to notify and cease payment of statutory payments in circumstances where the insurer considers the evidence gathered identifies fraudulent conduct/false and misleading statements. Guidance is required in relation to what steps are required in order to effect a cessation/reduction of payments and whether notice periods apply in those circumstances.

The Motor Accident Guidelines are silent in relation to the application of the obligations and penalties provided for by the Act. Clarification of the process required to notify an allegation of fraud/false and misleading conduct and the cessation of payments is required by the Motor Accident Guidelines.

…

There is no clear process with regard to how fraud is to be investigated by the Authority. The website does not set out a process and the Regulations/Rules etc. do not provide any further clarification as to how to utilise such a power. Industry feedback in relation to matters previously referred to the Authority for investigation and prosecution indicates limited response.

The firm set out a range of suggestions for amendments to the framework for deterring fraud.

The ICA's key concern in respect of fraud in the statutory benefits aspect of the Scheme relates to the onus on the insurer to establish that an injured driver was 'wholly or mostly' at fault. Statutory benefits cease at six months if an injured person was 'wholly or mostly' at fault. However, the injured person does not have to establish that they were not at fault. Rather, an insurer is only entitled to cease paying statutory benefits at 6 months if *it* can establish that the driver was at fault. In the case of an injured driver in a single-vehicle accident, it can be difficult or impossible to prove that the driver was at fault, simply because of a lack of evidence other than the driver's own statement.

In our view, this is the inevitable result of including a fault element in the statutory benefits aspect of the Scheme. It would not be appropriate to require injured persons to prove that they were not 'wholly or mostly' at fault in order to continue receiving statutory benefits past six months. If an insurer suspects that an injured driver was at fault but does not have the evidence to establish this as a fact, then it is appropriate that the insurer be obliged to continue paying statutory benefits. If an injured driver makes a dishonest statement to make it appear that they were not at fault even though as a matter of fact they were at fault, then it is reasonable to label the claim a partially fraudulent claim. However, the ICA's concern is in cases where this is suspected but not proved by evidence. It is arguable that such cases are not properly regarded as cases that should be addressed by the framework for deterring fraud, because there is no necessary conclusion that they are not valid claims.

The ICA raised some additional concerns,[143] including "pressure around the minor injury threshold", "access to the services necessary to discharge [insurers'] fraud related statutory obligations", and the fact that the

[143] ICA, *Submission to Review*, pages 21-22.

obligation on insurers to deter and prevent fraudulent claims[144] is less extensive than Objective (f), which is to deter fraud in connection with CTP insurance (i.e. not limited to claims).

Importantly, the ICA submitted that insurers:[145]

> *believe they now have sufficient experience in the Scheme under the Act to identify emerging trends that suggest fraud is present in the Scheme. There are a number of design features that Insurers consider make the Scheme vulnerable to fraud.*
>
> *…*
>
> *Insurers have amassed examples of behaviour that is contrary to the objectives of the legislation and consistent with fraud.*

We discussed these issues with the insurers and the ICA during the consultation meetings.

Several stakeholders made observations similar to the following from the ICA:[146]

> *CTP Insurers are not aware of any penalties having been issued under the fraud provisions of the Act. If it is the case that the Act penalty provisions have not been used, Insurers believe that this is not due to the absence of fraud in the Scheme.*
>
> *Insurers note that the Act provides SIRA with additional powers to detect and prosecute fraud. Insurers consider the existence of powers in the absence of their use (as we understand it) does little to deliver against Objective (f).*

Thus, we received a good deal of feedback in relation to fraud in the Scheme. The submissions we received on the insurer side of the Scheme were extensive, detailed and valuable. Despite this, we are not in a position to make any recommendations for amendments to the framework to achieve Objective (f).

The reasons for this are as follows:

- Detecting and deterring (and prosecuting) fraud are important aspects of the Scheme but the associated framework has the potential to impact the ease of access to statutory benefits by injured persons generally.
- Therefore, it is essential that any necessary changes to the framework are considered against valid and reliable data on the extent, method and cost of fraud actually occurring in the Scheme, so that changes can be correctly targeted at the issues.
- Law firms and insurers in the ordinary course of claim management are well-placed to gather anecdotal information on the extent and method of fraud in the Scheme. Their insights are invaluable in this regard, and should certainly be able to inform the gathering of representative data for analysis.
- The information available to the Review is at the stage of anecdotal information on the extent and method of fraud in the Scheme. In our view, that should not form the basis of recommendations for amendments to the framework for deterring fraud.

Deloitte's recommendations relating to Objective (f) in Part 4 of this report address the need to gather data to inform assessment of the framework.

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[144] Section 6.39 of the Act.

[145] ICA, *Submission to Review*, page 21.

[146] Ibid, page 22.

3.7 Objective (g) – Claim and dispute resolution

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

3.7.1 Introduction

In our Discussion Paper, we set out a high-level summary of the framework for making and resolving statutory benefits and damages claims, and the framework for resolving disputes.[147] In addition to asking general questions about Objective (g), we also asked questions about several matters relating to the resolution of claims and disputes including, among others:

- time limits to which claimants are subject;
- the internal review mechanism;
- the Scheme's framework for independent resolution of disputes;
- medico-legal assessments (opinion evidence about injuries); and
- the restrictions on access to paid legal advice in connection with disputes.

We address each of these matters below.

We have made several recommendations in the discussions against Objectives (a) and (b) that will, if adopted, make improvements to the framework for the resolution of claims. One way in which they would improve the framework is to make certain kinds of disputes that have a significant impact on injured persons less likely to occur.

While the Scheme needs to have a framework that supports the quick, cost-effective and just resolution of disputes, it is important to remember that quick, cost-effective and just resolution of disputes is no substitute for a claim management framework that supports good decision-making in the first instance, and avoids decision-making by insurers where it is not needed.

3.7.2 Time limits

Statutory benefits claims made more than 28 days after the accident

If a statutory benefits claim is made more than 28 days after the accident, then weekly payments of statutory benefits are not payable in respect of the period after the accident but before the claim was made.[148] There is no mechanism for relief for an injured person even if they miss this deadline through no fault of their own. Our Discussion Paper asked questions about this aspect of the Scheme[149] and most stakeholders agreed that it should be amended to allow for some flexibility. Our Recommendation 15 addresses this issue.

'Full and satisfactory' explanation for delay / failure to comply with a duty

A statutory benefits claim must in any event be made within 3 months of the motor accident concerned.[150] A claim may only be made after the 3-month time limit if the claimant provides a 'full and satisfactory'

[147] Discussion Paper, pages 31-38.

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

[149] Discussion Paper, Questions 68-69.

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

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 greater than 10%.[151]

The requirement for a claimant to provide a 'full and satisfactory' explanation for delay, or for failure to comply with a duty, applies in several provisions of Part 6 ('Motor accident claims') of the Act. In both cases, there is a threshold objective requirement for an explanation to be considered 'satisfactory':[152]

- 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 with the duty".

In our Discussion Paper, we asked stakeholders whether the test for failure to comply with a duty should be aligned with the test for delay.[153] Most stakeholders agreed that it should. The insurers did not agree, on the basis that the tests "are fundamentally designed to satisfy different issues in the claims management process".[154] However, that was the extent of the submissions we received in support of the current, differing tests.

While we agree that the tests address different issues, the test for failure to comply with a duty is exceptionally high. Currently, it is not sufficient to satisfy the test even if it is established that a reasonable person in the position of the claimant would have been justified failing to comply – it must be established that a reasonable person *would have failed* to comply. The rationale for this test is not evident in the legislation. Further, the consequences can be severe – for example, it can result in mandatory, summary dismissal of a claim for damages if the claimant fails to comply with the duty to give notice of the claim for damages "in the manner and containing the information required by the Motor Accident Guidelines".[155] Taking the example of an unrepresented claimant who notifies a claim for damages, such a claimant is, and should be, expected to comply with the duty. However, there will undoubtedly be circumstances in which a reasonable person in the position of such a claimant would be justified failing to comply with the duty. There could be far fewer circumstances in which it could be said that the reasonable person *would* fail to comply with the duty. We do not agree that, if the latter test is not satisfied but it is nevertheless established that the failure to comply with the duty was justified, then the result should be summary dismissal of the claim.

We recognise that the insurers and their lawyers need to be able to get the required information to deal with a claim for damages, and in a timely way. The duties of claimants that are affected by the 'full and satisfactory' explanation test generally concern the provision of information to the insurer. However, it appears to us that the consequences of failure to comply should still work appropriately if failure to comply can be excused – and can only be excused – if it is established that the failure was justified, from the point of view of a reasonable person. We consider that this will achieve an appropriate balance between the interests of insurers and claimants.

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

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

[153] Discussion Paper, Question 71.

[154] Suncorp, *Submission to Review*, page 14.

[155] Section 6.15(7) of the Act.

Recommendation 22

The legislature consider amending section 6.2(2) of the Act to amend the minimum requirement for a satisfactory explanation for failure to comply with a duty to: a reasonable person in the position of the claimant would have been justified failing to comply with the duty.

***Rationale**: The claims obligations on injured persons should operate fairly, so that those who act reasonably are protected from harsh consequences.*

Damages claims

Our Discussion Paper also asked about other time limits for steps in making and resolving claims. The feedback we received was addressed to the 20-month wait to claim damages for persons with permanent impairment of 10% or less and the accompanying prohibition on settling such claims within the first 24 months. Our Recommendation 17 addresses this issue.

3.7.3 Internal review

If a claimant disagrees with an insurer's decision, they may request the insurer to undertake an internal review of the decision.[156] 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.[157]

Timeframes for internal review are short. Section 7.9(4) of the Act provides that the insurer must notify the claimant of the outcome of an internal review within 14 days of receiving the claimant's request for the review. It also allows the Guidelines to provide for particular circumstances where the insurer has a longer timeframe for the review. Clause 7.25 provides that insurers have 21 days to complete internal reviews of certain categories of decision, and that if new information is submitted by the claimant, the insurer has a further 14 days after receiving the information.

Section 7.9(3) of the Act states that:

> The Motor Accident Guidelines may make provision for or with respect to the following:
>
> (a) the making of a request for an internal review,
>
> (b) the time within which a request for an internal review is to be made,
>
> (c) the individuals who may or may not conduct an internal review,
>
> (d) the way in which an internal review is to be conducted (including requiring the giving of reasons for and supporting documentation in relation to an insurer's decision on an internal review).

Clauses 7.4 to 7.29 of the Guidelines make provision for these matters. Notably, clauses 7.15 to 7.21 make provision for the internal review process as follows:

> **The internal reviewer**
>
> 7.15 An internal reviewer:
>
> (a) must have the required skills, experience, knowledge and capability to conduct the internal review in accordance with the objects of the Act
>
> (b) must not have been involved in making or advising on the insurer's initial decision or previously managed any aspect of the claim, or be someone the initial decision-maker reports to or manages directly

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

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

(c) may have previously conducted an internal review for the same claim.

The internal review process

7.16 The internal review must be conducted in the way that best supports the objects of the Act, given the facts and circumstances of the particular claim and the particular internal review, which may include undertaking the review on the papers, using teleconferences, video conferences or face-to-face meetings as appropriate.

7.17 The internal reviewer may determine the internal review procedure, is not bound by the rules of evidence and may inquire into any matter relevant to the issues under review in such manner as the internal reviewer thinks fit.

7.18 The claimant may submit new information to the insurer to be considered by the internal reviewer.

7.19 The internal reviewer may consider information that was not provided before the decision being reviewed was made, under Division 7.3, section 7.9(6) of the Act. The insurer must give any such information to the claimant if it has not already been provided to the claimant. The claimant must also be given the opportunity to respond to the information.

7.20 The insurer may reasonably request information from the claimant for the purposes of the internal review, which the claimant must provide, under section 7.9(2) of the Act.

7.21 If the claimant does not provide the insurer with the information reasonably requested, the insurer may decline to conduct an internal review.

In our view, subject to our Recommendation 4, these provisions should be adequate to form the basis of an effective review process.

The efficiency of internal review and its ability to produce a high quality of decision making are critically important to the design of the framework to achieve Objective (g). SIRA recognises the importance of internal review:[158]

> *the internal review is a very important structural part of the new system. There has been a lot of focus from SIRA as the regulator to ensure that that is working as intended. It is something that we will continue to monitor closely.*

A significant part of SIRA's focus to date has been on monitoring insurers' compliance with the timeframes for internal review.[159] We are not aware of the extent to which SIRA has adopted a wider focus.

In November 2020, Mr John Watts was commissioned by SIRA to conduct a review of a selection of insurer claim files, focused on insurer management of the internal review process in accordance with the Act and the Guidelines.

In his report, Mr Watts made observations in relation to each of the four insurers whose files he reviewed similar to the following, for 'Insurer A':[160]

> *The Claims Consultant advised me that:*
>
> - *The internal review personnel are completely separate to those making the decisions to be reviewed. The personnel in the Internal Review section do not handle claims. They are not part of the same division.*

[158] Law and Justice Review, *Hearing Transcript*, 26 May 2021, page 28 (Dr Casey).

[159] See, for example: Law and Justice Review, *Hearing Transcript*, 26 May 2021, page 28 (Ms Donnelly); SIRA, *Submission to Law and Justice Review*, page 19.

[160] J Watts, *Report of a review of a selection of insurer files relating to the insurer internal review processes*, page 5.

- *Reviewers are only appointed if they have the requisite skills, experience, knowledge, and capabilities to undertake the task. Recruitment is merit based and competitive. Recruits are then trained extensively and that there is ongoing training and mentoring.*
- *All decisions are peer reviewed before completion and there are regular meetings of the internal review team.*
- *All DRS decisions relating to Insurer A's matters are particularly discussed by the review team.*
- *Generally late review applications are accepted although sometimes an explanation is asked for. None of the files reviewed by me where the review application was late were rejected.*
- *I was provided with copies of internal documentation provided to reviewers relating to the obligations imposed by the Guidelines.*

Simply reviewing the files did not enable me to verify the above information but I observed nothing to indicate that it was incorrect in any way.

Mr Watts also concluded, in relation to each insurer:[161]

> *The files which I reviewed did not demonstrate any reluctance to overturn or to change a claims officer's decision. The review team appears to operate as an entity separate to, and independent of, the claims handling section.*
>
> *…*
>
> *My impression is that each of the insurers is taking seriously their obligations to conduct internal reviews in an independent and professional way…*
>
> *I observed nothing to suggest that any of the insurers had not acted in good faith or honestly or had misled the parties.*

Mr Watts' report makes clear that his brief did not extend to an audit of insurers' governance of the internal review process, or the characteristics and supervision of internal reviewers. The essence of the brief was to review a selection of insurer claim files, each of which included an application by the claimant for an internal review. The work proceeded as follows:[162]

> *The file examinations were conducted on-line with the assistance of a representative of each insurer, and in each case, I received full co-operation. Each representative was also able to assist me with answers to questions relating to the insurer's procedures and policies. In relation to some of the files I asked for certain documents to be emailed to me, and whatever I asked for was provided.*

In our view, Mr Watts made findings in terms that were appropriate to the limited nature of his brief to review insurers' compliance with their obligations.

In SIRA's March 2021 response to Mr Watts' report, SIRA stated the following:[163]

> *From the independent report it was identified that all insurers are demonstrating sound processes and an adequate approach to the internal review process. The findings highlight that each insurer appears to be independent in the decision-making process and insurer staff are competent and demonstrate the required skills to make fair and just determinations.*

We would not have concluded that Mr Watts made findings of this nature. Mr Watts stated in his report that he was not able to verify what the insurers told him about the following matters (among others):

- the independence of internal review personnel;

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[161] Ibid, pages 8, 12, 15 and 19.

[162] Ibid, page 2.

[163] SIRA, *SIRA's response to independent report on internal review*, March 2021, page 4.

- internal reviewers' skills, experience, knowledge and capabilities, and the nature of training for the job; and
- peer review of draft decisions.

Mr Watts did not set out any findings to the effect that "insurers are demonstrating sound processes" or that "insurer staff are competent and demonstrate the required skills to make fair and just determinations".

In evidence to the Law and Justice Review, the ICA also did not appreciate the limitations on the scope of Mr Watts' review and findings:[164]

> *Actually the finding of his review was that insurers are independent in their decision-making process, which is of course a key element of internal review, and that we are demonstrating the required skills to make fair and just determinations.*

The ALA, in its evidence to the Law and Justice Review, was critical of the apparent nature of Mr Watt's brief (but not, it should be clear, of Mr Watts himself):[165]

> *You were told by the insurers about the review that John Watts had done. He reviewed 50 files. They were randomly drawn. He looked across each insurer, at one or two wages decisions, one or two liability decisions and one or two minor injury decisions. Let us have the next review—and you can give it back to Mr Watts if he will do it or somebody else—and look at not a random selection of 50 but instead look at 50 where the insurer's internal review decision was overturned by the medical assessment or where their liability decision was overturned, and look at the learning across 50 files where they have been reversed to work out why and what are the common patterns of error that are occurring. If you look at 50 where you are lucky if you have one or two that were then disputed and then went further to be reversed and he did not look at any of that process, you are not going to pick up a great deal other than that their process appears superficially satisfactory. It is not a very good measure of what are we learning from the inaccurate outcomes, so pick a different sample next time.*

For our part, we make no criticism of the apparent scope of Mr Watts' brief. The review by Mr Watts that SIRA commissioned was a useful exercise and his report is valuable. But we agree with the ALA that independent reviews of internal review decisions that are overturned would also be valuable, to understand whether there are systemic issues that can be addressed. According to SIRA in its evidence to the Law and Justice Review, this is exactly what SIRA is already doing.[166] We support this and, of course, that the results of those reviews be made public.

Having regard to the structure of the Scheme and importance of the role of the internal review process, as well as stakeholder feedback to our Review, we consider that reviewing implementation of the internal review process and taking any action that may be needed to improve implementation are critically important aspects of SIRA's role in relation to the dispute resolution framework. We are not persuaded by the above conclusions about the implementation of the internal review process having regard to Mr Watts' stated findings. Further research is required to be satisfied that all insurers are demonstrating sound processes and an adequate approach to the internal review process and that insurer staff are competent and demonstrate the required skills to make fair and just determinations.

There are opportunities to dig deeper regarding the implementation of the internal review process. Deloitte makes recommendations directed to further and closer consideration of the implementation of the Scheme.

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[164] Law and Justice Review, *Hearing Transcript*, 25 May 2021, page 29 (Ms Isley).

[165] Ibid, page 53 (A Stone).

[166] Law and Justice Review, *Hearing Transcript*, 26 May 2021, page 28 (Ms Donnelly).

Feedback about internal review

Feedback about the internal review aspect of the Scheme was mixed. In terms of the framework, there are two important aspects of internal review to consider: the *existence* of the internal review mechanism and the *mandatory* nature of internal review before accessing independent dispute resolution.

We support the existence of internal review, particularly in relation to decisions associated with statutory benefits claims.

In relation to damages claims, one of the decisions to which mandatory internal review applies is the decision as to whether the injured person has a degree of impairment more than 10% (which is the gateway to damages for non-economic loss). Feedback to the Review by those who addressed this topic was unanimous to the effect that this decision is inappropriate for internal review. The ICA's submission in this respect was more circumspect than most but was nevertheless as follows:[167]

> *Despite the many benefits associated with internal review, Insurers understand that there are some disputes, such as those relating to an injured person's whole person impairment that are inherently technical and may be more quickly resolved by going straight to external assessment.*

We agree that the assessment of permanent impairment is appropriate to proceed directly to independent dispute resolution if there is disagreement between the claimant and the insurer.

Recommendation 23

The legislature consider amending section 7.9 of the Act to provide that Division 7.3 of the Act (Internal review) does not apply to a decision relating to the degree of permanent impairment of an injured person that has resulted from the injury caused by the motor accident (including whether the degree of permanent impairment is greater than a particular percentage).

***Rationale**: It is in the interests of all parties that decisions are made by persons who are best qualified to make them.*

Some stakeholders advocate for internal review to be optional for all, or most, disputes where the claimant disagrees with a decision by the insurer. Often this is on the basis that internal review introduces unnecessary delay. However, this argument does not hold for claimants who are successful at internal review – this achieves an overturn of the insurer's original decision more quickly than an overturn after consideration of the dispute by the PIC.

Plaintiff lawyers and insurers alike cite overturn rates at internal review as evidence either of the failure or the success of the internal review mechanism. But these overturn rates are difficult to interpret. If overturn rates for a particular type of dispute seem low, that might indicate that decision-making at the claim manager stage is generally good, or it might indicate that decision-making needs to improve both at the claim manager and the internal review stages – particularly if subsequent overturn rates in the PIC are relatively high. On this latter interpretation, it may be an indication that implementation of the Scheme needs to improve, rather than that the framework for dispute resolution needs to change.

The Law Society – which recognises that some issues with internal review may need to be resolved by improvements in implementation, rather than of the framework – advocates for the mandatory nature of internal review to be removed, on the basis that internal review often does no more than lead to delays. It is certainly the case that some claimants, who are unsuccessful at internal review but successful at the PIC, would achieve a resolution faster if they were able to bypass internal review. However, this can only be

[167] ICA, *Submission to Review*, page 26.

known in hindsight. Subject to one point,[168] we generally agree with the following submission by the ICA (on the basis that the references to 'customers' are references to claimants within the Scheme):[169]

> *Internal review can provide faster outcomes for injured people and reduce the cost and effort associated with referrals to* [the PIC] *borne by injured people, insurers and the Scheme more broadly.*
>
> *The internal review process provides several important customer benefits. Internal reviews:*
>
> - *Provide a simple and quick dispute resolution system.*
> - *Allow for faster resolution of disputes (usually 14-21 days) without the need to proceed through an adversarial system and without the need to access legal representation.*
> - *Allow for direct communication between the claimant and the internal review officer throughout the internal review process. This gives claimants the opportunity to voice their concerns and clarify issues during the process. It also allows for transparency, helping claimants to understand why a particular decision has been made.*
> - *Involve a less formal process than external review or litigation, and easier for a customer to understand and participate in.*
> - *Involve the use of a new decision maker who undertakes a review and makes a 'fresh' decision.*
> - *Can help avoid disputes unnecessarily proceeding down the external dispute resolution process (PIC).*
> - *Allow for continuous improvement in decision making by insurers.*
> - *Are cost effective as it does not add additional external legal fees within the Scheme.*

We are not recommending that internal review be made optional generally.

However, there is one respect in which we have concluded that an internal review should be optional. This arises where a particular aspect of an injured person's claim can be the subject of multiple decisions over the course of a claim. One example of how this can arise was set out in the ALA's submission to the Law and Justice Review.[170] In our view, where a particular aspect of a claim is subject to more than one dispute, this indicates that the matter may be appropriate for a binding, independent resolution. The claimant should be entitled to resolve the matter finally through an application to the PIC if they prefer to do so rather than participating in multiple rounds of internal review.

Currently, sections 7.11(3), 7.19(3) and 7.41(3) of the Act provide for the Regulations to prescribe *kinds* of decisions that are excluded from mandatory internal review before independent determination. We recommend that these provisions be expanded to enable the Regulations to prescribe *circumstances* in which internal review is not mandatory, and that the Regulations be amended to prescribe the circumstance where there has already been an internal review of the type of decision which is again the subject of a dispute.

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[168] In relation to the proposition that internal review proceeds "without the need to proceed through an adversarial system and without the need to access legal representation", we do not agree that internal review is a non-adversarial system, and the position is not that a claimant has no need to access legal representation – it is that a claimant has no right to access paid legal representation. That reduces the cost to the Scheme of an internal review, but does not necessarily make internal review 'cost-effective'. We revisit the issue of legal representation in internal review below.

[169] ICA, *Submission to Review*, page 25.

[170] ALA, *Submission to Law and Justice Review*, page 35.

Recommendation 24

The legislature consider amending each of sections 7.11(3), 7.19(3) and 7.41(3) of the Act to provide that, in addition to the regulations already permitted by those sections, the regulations may prescribe circumstances in which section 7.11, 7.19 or 7.41 (as the case may be) does not apply (thus having the effect that, in the prescribed circumstances, a claimant may proceed directly from the insurer's initial decision on a matter to dispute resolution under Division 7.4, Division 7.5 or Sub-division 3 of Division 7.6).

***Rationale**: The internal review mechanism is an important aspect of the Scheme but mandatory internal review is not appropriate in all circumstances.*

Recommendation 25

The Minister consider the making of regulations under sections 7.11(3), 7.19(3) and 7.41(3) of the Act, as amended in accordance with Recommendation 24, to prescribe the circumstance where the claimant and relevant insurer are in a dispute of a category that has already been the subject of an internal review in relation to the claim.

***Rationale**: The internal review mechanism is an important aspect of the Scheme but mandatory internal review is not appropriate in all circumstances.*

3.7.4 Independent resolution of statutory benefits disputes

The Act provides for independent resolution of statutory benefits disputes by the PIC established under the *Personal Injury Commission Act 2020* (**PIC Act**) or by decision-makers appointed by the Commissioner of the PIC.

Before establishment of the PIC, independent dispute resolution was provided through SIRA's Dispute Resolution Service (**DRS**).

Before we outline the framework for independent dispute resolution, we make the following observations about the PIC. The operation of the PIC is outside the scope of this Review because it is not governed by the Act. However, it has a critical role in the Scheme. It is essential to the Scheme that the PIC provides an efficient and timely process for dispute resolution. We received submissions from insurers and lawyers that there are very lengthy delays affecting decision-making by the PIC. This has negative consequences for injured persons, insurers and the Scheme generally.

In submissions to the Law and Justice Review, the Law Society proposed that one solution to delays in the PIC, in relation certain types of decisions, "would be for an amendment to the MAI Act to enable a stay of an insurer's earning capacity or minor injury decision, pending a [PIC] assessment".[171] There was mixed feedback about this proposal in submissions to the Review. For two reasons, we do not support it. First, it has the potential to increase the rate at which claimants lodge unmeritorious disputes in the PIC. Second, it is a solution to a problem of implementation of the existing framework. It would be better to improve implementation rather than amend the framework to accommodate a failure of implementation.

We urge the Government to work with the Commissioner of the PIC to address this situation. Doing so is essential to the success of the Scheme.

Outline of the framework

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.

[171] Law Society of NSW, *Submission to Law and Justice Review*, page 8.

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.

Claimants may request an internal review by an insurer of a decision about a matter in any of the above categories.[172] 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.[173] 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.[174]

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.[175] A 'merit reviewer' is a person appointed under the PIC Act to that position for the purposes of the Act.[176] 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.[177]

Claimants and insurers alike are bound by the decision of a merit reviewer,[178] 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".[179] 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.[180]

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.[181] For other merit review matters, fees for legal services are not allowed.[182]

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.[183] A 'medical assessor' is a person appointed under the PIC Act to that position for the purposes of the Act.[184] Evidence given for the purposes of a medical assessment (or a merit review) about any medical assessment matter is

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

[173] Clause 7.5 of the Guidelines.

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

[175] Section 7.12 of the Act.

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

[177] Section 7.13 of the Act.

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

[179] Section 7.15 of the Act.

[180] Ibid; section 7.14 of the Act.

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

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

[183] Section 7.20 of the Act.

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

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.[185]

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.[186]

The costs of medical assessments are payable by the relevant insurer.[187]

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.[188] There are provisions for interim assessment of permanent impairment if the medical assessor is not satisfied that the impairment has in fact become permanent.[189]

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.[190] 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).[191]

A merit reviewer may refer a medical assessment matter for re-assessment at any time.[192] 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.[193]

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.[194] The panel can confirm the certificate of the medical assessor or revoke that certificate and issue a new one.[195]

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

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[185] 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.

[186] 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).

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

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

[189] Section 7.22 of the Act.

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

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

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

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

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

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

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.[196] 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.[197] 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.

3.7.5 Overturn of insurer decisions

The Act places in the hands of an insurer a large number of decisions in the management of statutory benefits claims. These decisions concern, on one hand, the entitlements of claimants and on the other, the liabilities of the insurers themselves. There is a significant imbalance between the position of claimant and insurer. The Act imposes, appropriately, duties on insurers. However, in the context of Objective (g), we consider that particular focus needs to be given to decisions by insurers as they deal with claims in accordance with their duties.

For reasons discussed earlier in this report, we have concluded that there is an issue in the statutory benefits and dispute resolution frameworks of the Act, in that the frameworks lack the necessary mechanisms to incentivise investment by insurers in good decision-making. Our views are supported by feedback to the Review about the experience of some claimants and health practitioners in the Scheme, which feedback is consistent with SIRA's published data both on claimants' experiences in the Scheme[198] and the frequency of disputes and overturned insurer decisions in the Scheme.

The Scheme needs to support insurers to continue to strive to make the right decisions. This requires a concrete framework for measurement and management of the quality of decision-making in addition to more general provisions addressed to 'culture'. We recommend a framework, to be set out in the Guidelines and enabled by an amendment to the Act, to incentivise quality decision-making in the interests of injured persons and, crucially, to incentivise insurers to invest in well-trained and well-qualified decision-makers who have the time and ability to make decisions, in all claims, in which the insurers and injured persons alike should have confidence.

The framework we recommend would require insurers to remain within acceptable rates of 'overturn' upon independent resolution of disputes by the PIC, compared with the number of decisions they make overall. Appropriate overturn rates may be different for different types of decision. The rates must be set at a level that requires insurers to consider very carefully any decision, for example, to dispute treatment and care recommended by a treating practitioner, or to decline ongoing statutory benefits on the basis of minor injury.

Deloitte recommend an independent claim file review of claims that did not go through the DRS, however displayed similar characteristics to those that were overturned in favour of the claimant at the DRS to further glean insights into the appropriateness of internal reviews. The outcomes of that review would likely assist SIRA in relation to decisions as to the Guidelines setting maximum acceptable overturn rates.

Our recommendation does not involve any assumption about how the claim managers at any particular insurer currently conduct claims. To the extent that insurers currently conduct claims in the way that this recommendation seeks to support – and we recognise that many claims are indeed conducted in this way – then the framework will not affect that conduct. However, the framework we propose will support insurers to

[196] Section 7.42 of the Act.

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

[198] See: Social Research Centre, *SIRA Regulatory Measurement of Customer Experience and Outcomes Study*, November 2020, Part 2.

ensure that a higher proportion of claimants have a satisfactory experience within the Scheme in terms of the timely resolution of claims.

Currently, a claimant who is aggrieved by the relevant insurer's decision can lodge a dispute with the PIC if they wish, and if the insurer's decision is overturned then the insurer will simply pay the benefits accordingly. This is inherently a poor outcome for the claimant because of the delay and possibly stress involved in proceeding through a dispute. However, the delay may be of no consequence to the insurer, and the dispute resolution framework provides no consequence for the insurer as a result of failing to make the right decision in the first instance.

We received some submissions to the effect that insurers should face potential penalties if a decision in a particular case is reversed, in some circumstances.[199] Except in the case of serious misconduct – for which the framework already provides consequences – we do not agree with submissions to that effect. An insurer should be entitled to proceed in accordance with its reasonably held view of view of its own liabilities, subject to correction by a body with authority to make a binding determination.

Having said that, we do consider that it would be appropriate for the framework to provide for consequences if high standards are not maintained over a period of time across a number of cases.

If claimants have adequate access to legal advice, an insurer should expect poor decisions to be overturned by the PIC. However, if the Scheme is working well, then straightforward cases should not have to be resolved by the PIC very often. This is because, particularly with access to appropriate legal advice, we expect that claimants should rarely dispute decisions that are clearly right, and insurers should rarely make decisions that are clearly wrong. Therefore, we would expect that generally the ratio of decisions overturned in the PIC to decisions not overturned should be relatively even.

There will always be cases where the right decision on an issue arising in a statutory benefits claim is difficult to determine. Decisions in such cases should be more likely than others to need formal dispute resolution, and some will inevitably be overturned. However, if insurers generally make good decisions, then the result should be that only few of them are ever overturned in the PIC as a result of an application for independent resolution by a claimant. In our view, SIRA could make use of this proposition to incentivise and support good decision-making by insurers.

Technically, maximum acceptable overturn rates in respect of an insurer's decisions in statutory benefits claims should operate on the ratio of the number of the insurer's decisions overturned in the PIC in a given period to the total number of statutory benefits decisions made by the insurer in the same period that are capable of dispute (i.e. in any of the dispute categories in Schedule 2 to the Act that relate to statutory benefits). We anticipate that the latter figure may be difficult to put into practice, and we suggest that the number of statutory benefits claims in the period could serve as a proxy.

In respect of the 'overturn' of decisions, it is important that the framework we recommend includes cases where a dispute is withdrawn from the PIC, because otherwise an insurer could avoid registering an 'overturn' by changing its decision after the dispute is lodged, resulting in withdrawal of the dispute. Although this is certainly what should occur if the insurer changes its decision, these cases must still register as an 'overturn', otherwise the framework may not be effective to incentivise good decision-making at earlier stages. If an insurer considers that information that was material to the new decision became available only after it made the decision that was the subject of the dispute lodged with the PIC, then the framework would enable the insurer to seek to have the matter excluded from its overturn rate.

Compliance with the Guidelines is a condition of an insurer's licence under the Act, and a breach of the Guidelines can attract the operation of section 9.10 of the Act which authorises SIRA to impose a civil penalty in the event of a breach of an insurer's licence. The framework we recommend draws on SIRA's power under section 9.10. In principle, an alternative and possibly better incentive for insurers would be

[199] For example, see ALA, *Submission to Review*, page 18; Stephen Young Lawyers, *Submission to Review*, page 2.

financial reward rather than financial penalty.[200] We make no recommendation for a financial reward but this could be considered in a future review of the Act, Regulations and Guidelines.

Recommendation 26

The legislature consider amending the Act to provide that the Guidelines may prescribe maximum acceptable overturn rates in relation to a licensed insurer's statutory benefits decisions that are the subject of merit review, medical assessment and miscellaneous claims assessment under the Act on referral by the claimant.

***Rationale**: The Scheme should support insurers to continue to strive to make the right decisions.*

Recommendation 27

SIRA should issue Guidelines setting maximum acceptable overturn rates in relation to statutory benefits decisions that are the subject of merit review, medical assessment and miscellaneous claims assessment under the Act on referral by the claimant. The Guidelines should:

(a) specify the maximum acceptable overturn rates, which may be separate rates for merit review, medical assessment and miscellaneous claims assessment matters;

(b) specify that:

  (i) 'overturn' means that the decision of the merit reviewer, medical assessor or the Commission is more favourable to the claimant than the insurer's decision;

  (ii) 'overturn rate' of an insurer means the ratio of 'overturned' decisions by the insurer in a given period to the number of statutory benefits claims managed by the insurer in the same period (including claims managed on behalf of the Nominal Defendant or other insurers).

  (iii) overturn rates include disputes that are withdrawn after the referral by the claimant, if the withdrawal follows a change by the insurer to the decision under dispute. Withdrawals under those circumstances must be notified to SIRA by the insurer; and

  (iv) overturn rates do not include any decision where:

    (A) the merit reviewer, medical assessor or the Commission certifies that information that was material to the decision was not available to the insurer when the decision under dispute was made; or

    (B) in respect of a dispute that is withdrawn after the referral by the claimant and following change by the insurer to its decision, the insurer satisfies SIRA that the change to its decision followed the provision of information that was material and was not available to the insurer when it made the decision that was under dispute;

(c) provide that SIRA will continuously monitor, and publish on its website, the overturn rates of each licensed insurer, and may obtain information from licensed insurers and the Commission for that purpose;

(d) provide for SIRA to require remedial action by the insurer in the event that the overturn rate in respect of the insurer's decisions in any 6 month period exceeds the relevant maximum, and

[200] For an example, see clause 8 of the TEPL Guidelines which creates a mechanism for insurers to retain additional profit for successful innovations that promote the Objectives of the Act and benefit participants in the Scheme.

provide that a failure to undertake the required remedial action is a breach of the Guidelines; and

(e) provide that, if a licensed insurer exceeds an overturn rate across any 12-month period, this constitutes a breach of the Guidelines.

***Rationale**: The Scheme should support insurers to continue to strive to make the right decisions.*

3.7.6 Miscellaneous claims assessment provisions

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. Section 7.42(2) in Subdivision 3 provides that:

> Subdivision 2 applies to the assessment of a dispute in the same way as it applies to the assessment of a claim for damages, subject to subsection (3) and such other modifications as may be prescribed by the regulations.

Subdivision 2 governs assessment by the PIC of claims for damages. The Regulations make extensive modifications to adapt the provisions of Subdivision 2 for the purposes of Subdivision 3.

Subsection (3) of section 7.42 in Subdivision 3 is necessary in order to apply to statutory benefits disputes the provisions governing the extent to which assessments of damages claims are binding, and provides that:

> An assessment of a dispute about a miscellaneous claims assessment matter relating to a claim for statutory benefits is binding on the parties to the dispute.

The result of all of this is that the provisions are difficult to read and confusing. It would be better to have the framework for miscellaneous claims assessment set out in the usual way, in one place.

Recommendation 28

The legislature consider amending Subdivision 3 of Division 7.6 of the Act to adopt a simpler approach to the drafting of the provisions governing miscellaneous claims assessment, in particular having regard to the current section 7.42(2).

***Rationale**: The drafting of the Act should not be more complex than is needed to give effect to the Scheme design.*

3.7.7 Medical opinion

Authoritative medical opinion: 'medical assessment'

Division 7.5 of the Act sets out a dispute resolution pathway for disputes about 'medical assessment matters'. A dispute about a medical assessment matter may be referred to the President of the PIC to arrange for 'medical assessment' of the matter by a 'medical assessor'. The referral may be made either by the claimant, the insurer, a PIC merit reviewer, the PIC itself (e.g. on the assessment of a damages claim) or by a court.

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.[201] A merit reviewer may refer a medical assessment matter for re-assessment at any time.[202] Both the claimant and the insurer may, each on one

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

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

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.[203]

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.[204] The panel can confirm the certificate of the medical assessor or revoke that certificate and issue a new one.[205]

Opinion evidence

If the claimant or the insurer wish to rely, in a statutory benefits or damages dispute, on opinion evidence about a 'medical matter' (which is the same as a 'medical assessment matter'), then there are restrictions that apply. Reliance may only be placed on such opinion evidence if it is given by:[206]

- a treating health practitioner of the claimant;
- a health practitioner whom the claimant and insurer have agreed to appoint for the purpose of giving the opinion;
- a health practitioner who is on SIRA's list of 'authorised health practitioners' (**AHPs**); or
- a health practitioner who SIRA has appointed for a specific purpose and duration, upon application by a claimant or insurer.

Therefore if either party wants to obtain opinion evidence from a non-treating health practitioner of the claimant, and the parties do not agree on the joint appointment of a single practitioner for that purpose, then the party wanting the opinion must generally choose an AHP (a health practitioner authorised by SIRA to give opinions for the purposes of section 7.52 of the Act) to undertake an assessment of the matter and give an opinion. This would usually involve an interview or examination of the claimant by the practitioner.

According to SIRA:[207]

> *The key objective in authorising health practitioners is to support the injured person's customer experience and encourage the early resolution of motor accident claims and the quick, cost-effective and just resolution of disputes.*

More specifically, according to SIRA:[208]

> *AHPs were introduced to the* [Scheme] *to encourage joint medicolegal examinations with the aim to minimise disputation and reduce claim resolution times.*

It is not entirely clear how the AHP framework will encourage the use of joint medico-legal examinations, given that the status of an expert as an AHP is only a requirement if the parties are *not* undertaking a joint medico-legal examination. Furthermore, most of the feedback to the Review on this topic was in agreement that the Scheme's framework should do so. Joint examinations mean fewer medical examinations of the claimant and may help the parties to reach agreement on facts about the claimant's injuries.

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

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

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

[206] Section 7.52 of the Act and clause 8.3 of the Guidelines.

[207] SIRA, *Post Implementation Review of the Authorised Health Practitioner (AHP) Framework*, July 2021, page 6.

[208] Ibid, page 4.

SIRA has a consultation process currently underway in relation to the AHP framework. A discussion paper was published in July 2021[209] and written submissions in response to the paper closed on 6 August 2021. In the discussion paper, SIRA explained:[210]

> *The review will consider whether the framework is operating effectively and as intended. In scope will be a consideration of the appropriateness and effectiveness of the framework, associated administrative processes, the customer experience of injured persons, in addition to training or support requirements for practitioners …*
>
> *Feedback is being sought from key stakeholders and scheme participants on how the framework is operating.*

The stakeholders who gave feedback to the Review on this topic – lawyers and insurers – are repeat users of medical opinion evidence and are universal in their view that the AHP framework does not achieve its objectives, and only serves to introduce additional administrative burdens on participants in the Scheme.

In our view, the Scheme would benefit from measures that directly facilitate and incentivise the use of joint medico-legal assessments. There is more work, beyond that which could be achieved by this Review, required to assess in detail and consult specifically on proposals for such measures.

We recommend that SIRA undertake a consultation, first to obtain views and information about options to facilitate or incentivise the use of joint medico-legal assessments, and then in a second stage to consult on specific proposals.

SIRA could consider a facility where parties who agree to undertake a joint medico-legal assessment can ask SIRA to select the assessor, whom the parties must then appoint. SIRA should also canvass widely for other options in the consultation.

The consultation should also review the fees payable within the Scheme to health practitioners who provide opinion evidence. It is essential that the available fees be set at a level that can attract the participation of a wide range of persons with the appropriate skills and experience.

Recommendation 29

SIRA should undertake a consultation to determine changes to the Scheme that directly facilitate and incentivise the use of joint medico-legal assessments in relation to claims for damages, as well as a program of data collection to assess the efficacy of the changes.

***Rationale**: Joint medico-legal assessments may not be appropriate in every case but they have the potential to support the claimant's experience and encourage the early resolution of motor accident claims and the quick, cost-effective and just resolution of disputes.*

3.7.8 Restrictions on access to paid legal advice

The legislation sets out a detailed and complex framework which aims both to restrict access to legal advice and representation in the course of statutory benefits claims, and to restrict the fees that lawyers may charge for their work within the Scheme.

These are not ends in themselves. They are intended to facilitate achievement of the Act's Objectives – particularly Objective (g) – and to limit the costs of running the Scheme to keep CTP premiums affordable.

In this discussion, we leave aside the role of unpaid legal work in the Scheme. There is no restriction on claimants accessing *pro bono* legal services, but the Scheme should not be structured in a way that relies on legal services being provided *pro bono*. In addition, where we discuss restrictions on access to legal services in the claim management and internal review stages of decision-making, we are concerned primarily with restrictions on claimants' access to legal services, even though the restrictions apply to insurers as well. This is because there are a variety of ways in which insurers can access the legal services they wish to

[209] Ibid.

[210] Ibid, page 3.

have, despite the restrictions in the legislation. One example is simply to employ lawyers with whatever skills, expertise and experience the insurer wishes to be able to access.

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 medical examination services within the Scheme. An independent review into legal support within the Scheme for injured persons was commissioned by SIRA. On 17 September 2021, SIRA published as part of this review a report by analytics and actuarial consulting firm, Taylor Fry.[211] The aim of the review is to assess whether the current framework for legal support and service provision by practitioners is promoting the objects of the Act.[212]

Claimants are restricted from accessing legal advice or advocacy at the claim management and internal review stages of insurer decision-making on statutory benefits claims. Claimants may access legal advice and advocacy in connection with certain types of statutory benefits disputes lodged with the PIC. In these cases, the amount payable is limited (notionally corresponding to 4 hours of work), and the insurer is required to pay for the legal services rendered to the claimant. There is a framework for the PIC to allow a higher fee to be paid to claimant lawyers than ordinarily applies, and this must also be paid by the insurer. However, a higher fee would generally only be allowed after the dispute has been resolved. If a claimant's lawyers undertake a significant amount of work in a dispute, then there is a risk that they will not be paid accordingly if the PIC does not make an order allowing it. There is no framework for insurers' lawyers to be paid a higher fee.

Claimants are free to access (and pay for) legal services in connection with making and prosecuting damages claims. Restrictions apply to the amount of fees that may be charged in connection with a damages claim.

SIRA recognises the need for some claimants to be able to access legal advice in circumstances where the restrictions under the legislation apply. It operates a 'Legal Advisory Service' (**LAS**) within the broader 'CTP Assist' service that makes available 3 hours of legal services to a claimant, provided by a solicitor from a panel contracted to SIRA, upon referral by CTP Assist. The claimant is not required to pay for the advice. LAS is not available to assist in relation to applications for internal review, or on matters where the legislation allows access to paid legal advice.

In May 2019, SIRA published an independent report commissioned into the operation of LAS, which at that time had been running as a pilot program. The report found that the service was valuable, should move out of the pilot phase, and that steps should be taken to "increase awareness and potential utilisation of the service."[213]

The author of the report, Dr Andrew Fronsko, consulted with claimants who had used the service, CTP Assist staff, LAS panel solicitors, other solicitor stakeholders, SIRA personnel, and the insurers. His report included the following observations in its executive summary:[214]

> *The service provides a 'safety net' that enables eligible claimants to access legal advice in circumstances where this may not be otherwise available. There is consensus that the service can fill a gap in access to professional services, and that the provision of a 'safety net' is meritorious and beneficial.*
>
> *There is a compelling case for providing free and accessible legal advice for injured people to enable them to make judgements about the merits of challenging insurer decisions or to provide assurance that the insurers decisions are sound, lawful and consistent with evidence obtained.*

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[211] Taylor Fry, *Review of legal support for people injured in the NSW CTP Scheme*, 3 September 2021.

[212] SIRA, *Submission to Law and Justice Review*, page 28.

[213] A Fronsko, *Report of the Independent Review of the Operation of SIRA's Legal Advisory Service Pilot*, May 2019, page 8.

[214] Ibid, page 7.

> *There is also a strong argument in ensuring claimants can navigate the system to gain access to benefits that will assist their recovery and to exercise their rights in circumstances where they disagree with decisions by an insurer. There is accountability upon insurers to ensure claimants are fully informed on their rights and obligations and the basis of claims decisions. This will remain an essential core service offering, particularly in circumstances where lawyers cannot be paid for, or recover costs for providing advice on certain matters related to obtaining statutory benefits.*

Dr Fronsko also concluded that CTP Assist should continue to act as the 'gatekeeper' for access to LAS.[215]

The Act and the Regulations are complex for someone without legal training to read and understand. In our view it is essential that injured persons are permitted to access advice on their rights under the Scheme, and assistance to advocate their claims. The question is how and from whom they should access that advice, and how it is funded, having regard to the balance to be achieved between the various Objectives of the Act.

In consultation discussions, the insurers did not agree with the proposition that claimants need to advocate for their rights in connection with statutory benefits claims. We believe that they do. A simple example serves to illustrate the point.

A claimant has a spouse who dies in a vehicle crash which was caused by the fault of another driver. In the months and years that follow, the claimant has a diagnosis of post-traumatic stress disorder and receives weekly payments in respect of lost income due to loss of earning capacity. Under section 3.15(1)(a) of the Act, the claimant is obliged to give certificates of fitness for work to the insurer, provided by a treating practitioner. Under section 3.15(3)(b), the certificate must certify the status of the claimant's fitness for work for a period not exceeding 28 days. Therefore, every 28 days the claimant attends their general practitioner to obtain the next certificate in respect of their PTSD. The claimant experiences this as stressful and unnecessary, because it is tantamount to an exercise in continuously validating their trauma, and at times it places strain on the claimant's relationship with their GP. If the claimant misses the 28-day deadline for the next certificate, the insurer's claim manager contacts the claimant about it. This may be appropriate – the claim manager is doing their job – but potentially compounds the stress.

This example is not hypothetical, but based on the actual experience of a claimant in the Scheme.

The question arises as to who will explain to the claimant the effect of sections 3.15(4)(a) and (5) of the Act, which provide that a GP may give a certificate covering a longer period – up to 90 days – if the GP states in the certificate the special reasons why the certificate covers the longer period? Whether a GP will provide such a certificate is a matter for them, but one can be confident that the claimant will not get it if they do not know that they can ask for it.

Further, section 3.15(4)(b) provides that the certificate will only be effective if "the insurer is satisfied that, for the special reasons stated, the certificate should be accepted." Who will assist the claimant to present their case that the insurer should accept the certificate? Who will advise the claimant how to advocate their claim? Neither the insurer nor CTP Assist are in a position to do this. The answer is that no one will give this kind of assistance to the claimant unless they have access to legal services.

The feedback we received from a variety of stakeholders is that the Scheme is too complex for individual claimants to be able to navigate effectively on their own. A number of claimants with whom we spoke, plainly did not have the ability – or capacity, having regard to their injuries – to advocate effectively for their rights with the benefit of an informed understanding of the Act and its Regulations and Guidelines. The result is that claimants without legal assistance are entirely in the hands of the relevant insurer and the claim manager to whom at any given time their case is assigned. For many claimants, this will be adequate for them to be able to access the support that they need and to which they are entitled. However, for others, the framework will be inappropriate because insurers are simply not in a position to be the legal adviser and advocate for the injured persons whose claims they manage.

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[215] Ibid.

SIRA's Legal Support Review

SIRA currently has underway a review of legal support in the Scheme (**Legal Support Review**). One of the issues being considered in the Legal Support Review is the framework itself for access by claimants to legal support, including whether the Independent Legal Assistance and Review Service (**ILARS**) that operates in the workers compensation scheme should be extended to the CTP Scheme. Many stakeholders consider that it should.

The IRO provided to the Review a submission as follows (citations omitted):[216]

> *There is … a substantial evidence base that indicates the current restricted access to paid legal advice does not help secure, and in all likelihood hinders the objectives of the Act.*
>
> *Conversely, access to appropriate legal services can promote many of the policy objectives of the Act, including access by injured persons to treatment and income support and quick, cost effective and just resolution of disputes. The response of the NSW Government to limited access to legal advice in the workers compensation system (a change in workers compensation legislation in December 2012 resulted in each party to a claim or dispute being required to 'bear their own costs') was to establish the ILARS.*
>
> *The IRO administers ILARS, which provides funding:*
>
> - *for legal and associated costs for workers under the Workers Compensation Acts seeking advice regarding decisions of insurers*
> - *to provide assistance in finding solutions for disputes between workers and insurers.*
>
> *ILARS is strongly supported by those who represent workers, as demonstrated recently in evidence before the* [NSW Legislative Council Standing Committee on Law and Justice]. *The Committee recommended the Government expand WIRO* [Workers Compensation Independent Review Office] *services and ILARS to CTP claimants (recommendation 3). This recommendation was implemented in part in the PIC Act* [Personal Injury Commission Act 2020] *by expanding the IRO complaint function. An external assessment of ILARS conducted by the Nous Group in 2020 also found external stakeholders highly value ILARS, which was seen as accessible and expert, as seeking outcomes which were fair to all stakeholders and as responsive to feedback.*
>
> *This evidence suggests ILARS provides a possible model to redress legal assistance deficiencies in the current CTP scheme.*

Schedule 5 to the PIC Act establishes the IRO. Clause 12 in Schedule 5 provides that the Standing Committee on Law and Justice must, in its 2022 review of the Scheme, enquire into and report on the whether ILARS should be extended to claimants for statutory benefits under the Act.

Shortly before finalising this report, SIRA published a paper prepared by consulting firm Taylor Fry on the appropriate model for access to legal support, including consideration of introducing ILARS to the Scheme. We have not had sufficient time to consider the Taylor Fry report, and it was released after our stakeholder consultation process so we did not consult with stakeholders on it. We will not comment on the Taylor Fry report or its findings. We simply make some observations that we hope will assist those tasked with carrying out the Legal Support Review and recommending a model for access to legal support and resolving other issues that have arisen in relation to the framework governing legal support for claimants.

Reviewing the model for access to legal support

In our view, consideration of the appropriate model for access to legal support should be guided by the following principles, among any others considered relevant:

1. The restrictions on access to legal advice and representation in the course of statutory benefits claims, and the restrictions on the fees that lawyers may charge for their work within the Scheme, are not ends in themselves. Rather, the Scheme's model for access to legal support must be a

[216] IRO, *Submission to Review*, pages 7 - 8.

means to facilitate achievement of the Act's Objectives and to limit the costs of the Scheme to keep CTP premiums affordable.

2. The experience of a number of claimants in the Scheme bears out the self-evident proposition that many injured persons will benefit from having access to the services of a professional adviser and advocate, in terms of accessing entitlements under a complex scheme of statutory benefits where decisions are made by a person (the relevant insurer) whose interests are not necessarily the same as those of the claimant.

3. Taylor Fry's report indicates that legally advised claimants are more likely to achieve a good outcome in terms of access to entitlements. However, access to the services of a professional adviser and advocate also has the potential to improve a claimant's experience in the Scheme generally by reducing the burden on the claimant themselves in respect of understanding and advocating for their entitlements to statutory benefits, so they can focus on recovery.

4. The CTP Assist service is an important aspect of the Scheme but cannot replace the role of a lawyer who can both advocate for the injured person, and provide advice for the person's individual circumstances.

5. Legal support for injured persons does not only concern the resolution of disputes, but also the appropriate presentation of the claim and the giving of proper and useful assistance by the claimant to the decision-maker to make a good decision as early as possible.

6. Whether a person has the benefit of legal advice does not make the Scheme more or less 'adversarial', except insofar as this is a reference to the manner in which claimants and insurers conduct themselves. To the extent that the concern is 'adversarial' conduct by insurers, this is a matter for insurers and for SIRA as the regulator of their conduct, and should not affect consideration as to whether injured persons should be able to access the advice and advocacy of a lawyer. Similarly, the legal profession is subject to regulation and legal practitioners must meet standards of professional conduct or face sanction.

Reviewing other issues associated with the framework

In addition to the model for access to legal support, there are a range of issues in the current framework for legal support in the Scheme that warrant consideration. We consider that careful consideration should be given to introducing ILARS into the Scheme, although that may not address all of the current issues. We have not been provided with all of the stakeholder submissions to the Legal Support Review, although some stakeholders did provide us with a copy of their submission. Several stakeholders have made detailed submissions to us, to the Law and Justice Review or to the Legal Support Review about issues associated with legal support in the Scheme, beyond the model for access to legal services in connection with statutory benefits claims. In addition to consideration on the broader framework for how claimants access legal support, an outcome of the Legal Support Review should be consideration of those issues.

The provisions of Part 8 of the Act and the associated Regulations require a full review to ensure that they work as intended, and problems identified in submissions to the Law and Justice Review, the Legal Support Review, and this Review under section 11.13 of the Act are considered and addressed. These issues include, among other things:

1. the need for straightforward and timely access to the regulated fee that is due to claimant lawyers and payable by insurers for statutory benefits disputes. The Scheme should avoid follow-up disputes about a claimant lawyer's entitlement to be paid for their work;

2. whether it remains appropriate that claimants are denied access to legal services in relation to some types of statutory benefits disputes;

3. clarity of provisions governing costs in complex or other exceptional cases;

4. consideration of the 'contracting out' provisions for damages, including whether the threshold should work differently for insurer and claimant lawyers;

5. the need to ensure that fees payable for legal services are sufficient to enable experienced practitioners to remain active in the Scheme;

6. provisions that lead to lower legal fees payable for better Scheme outcomes should be considered closely, to ensure that the lower fee in fact corresponds to a lesser amount of work (rather than disadvantaging lawyers when they adopt approaches to dispute resolution that benefit their clients and the Scheme generally).

Since Taylor Fry have now released their report, it is appropriate for that to be considered and discussed. Further, we are aware that several stakeholders made submissions to the Legal Support Review about legal support in the Scheme, but not to our Review. Those stakeholders are entitled to have their submissions considered in the making of any recommendations. We will therefore not make specific recommendations which pre-empt the conclusion of the Legal Support Review.

Recommendation 30

SIRA should develop and consult on recommended changes to the provisions of the Act and Regulations that govern the provision of legal support in the Scheme.

Rationale*: Scheme outcomes and injured persons' experience in the Scheme will often benefit from access to the services of an adviser and advocate.*

3.7.9 Independent Review Officer

The Office of the Independent Review Officer (**IRO**) is an independent statutory office and public service agency established under the PIC Act from 1 March 2021. It is a recent addition to the Scheme.

The statutory functions of the Independent Review Officer are set out in Schedule 5, Part 3, cl 6 of the PIC Act and include, relevantly to the Scheme:

- to deal with complaints about any act or omission of an insurer that affects the entitlements, rights or obligations of the claimant under the Act; and
- to inquire into and report to the Minister on any matters arising in connection with the operation of the Act either by own motion or on referral from the Minister.

The IRO also manages and administers ILARS in the workers compensation scheme, which aims to ensure that injured workers have access to lawyers who are expert at workers compensation law and practice to advise, assist and represent them in accessing workers compensation entitlements.

One of the important changes effected by the PIC Act was the new function from 1 March 2021 to deal with complaints by persons injured in motor accidents under the Scheme and to assist in finding solutions. This function was previously performed by SIRA.

Feedback to the Review is that the service offered by the IRO is not yet widely known. Currently there is no obligation on insurers to notify claimants about the IRO. Moreover, feedback to the Review suggests that some disagreements about statutory benefits could be more quickly and easily resolved via the IRO rather than the formal dispute pathway.

We recommend that insurers be required to give details of the IRO to injured persons at the beginning of the claim process and at points in the claim process when complaints or disputes are most likely to arise.

Recommendation 31

SIRA should amend the Guidelines to require the relevant insurer for a claim to include contact details for the Independent Review Office and a description of the service provided by the Independent Review Office in respect of complaints about insurers in:

(a) the written notice to the claimant under section 6.19(1) of the Act; and

(b) each written notice to the claimant of a decision:

(i) to decline to pay a statutory benefit that was claimed, or to cease paying statutory benefits (including on the basis of minor injury or fault);

(ii) not to approve treatment and care, or not to approve treatment and care in full;

(iii) relating to the amount of weekly payments payable to the claimant, unless the decision is to pay an amount equal to an amount that was claimed; and

(iv) as to the degree of permanent impairment of the claimant, if the decision is not consistent with opinion submitted to the insurer by or on behalf of the claimant.

***Rationale**: Insurers should tell injured persons about their options to resolve complaints.*

3.8 Objective (h) – Collection and use of data

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

3.8.1 Introduction

Submissions to the Review generally supported this objective and the framework to achieve it. However, the insurers and others have raised some concerns about the collection of data and a variety of stakeholders made submissions about the use and particularly disclosure of information by SIRA.

3.8.2 Collection of insurer data

The legislative framework for Objective (h) insofar as it relates to the collection of data by SIRA 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.[217] SIRA may obtain this data from insurers, relevant insurance or compensation authorities, hospitals, government agencies, and from any other source.[218]

In relation to insurers specifically, they 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*.

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.

Both the ICA on behalf of the insurers, and Suncorp on its own account, raised some concerns related to SIRA's collection of data. The ICA submitted that insurers:[219]

> *consider that the Guidelines could be amended to promote certainty in what must be provided to SIRA to support the other objectives of the Scheme. Insurers also note that systems development and change*

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

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

[219] ICA, *Submission to Review*, page 30.

associated with meeting data requirements and the going operation of the system come at a cost to the Scheme.

Suncorp made a submission as follows:[220]

Suncorp puts forward the following recommendations for changes to the UCD Manual/Guidelines to secure, or better secure, objective H:

- *We recommend that SIRA conduct in depth consultation and analysis before introducing new requirements or requesting for additional data. The purpose of this is to prevent the rework of UCD by insurers without gaining a proper understanding of the benefits and rationale for such proposed changes. As we have seen, previous upgrades to the UCD had primarily been addressing gaps that were not considered at the time of Scheme inception or during the launch of the UCD system.*
- *In one example, SIRA requested we migrate from AIS 2008 to AIS 2015. As a result, we had to review and update all open and closed claims we had received since Scheme inception. We note AIS 2015 was available from the start of the Scheme but was not considered at that time.*
- *Since Scheme inception, SIRA has on multiple occasions requested the industry to provide additional data (in addition to what is required in the UCD). These requests can be complex, expensive, time consuming and resource intensive and require insurers to divert front line team members away from managing claims and assisting injured people. For future purposes, we recommend that SIRA conduct proper consideration as to whether any of the data request is justified including its cost benefits.*
- *Similarly, the ability of SIRA's UCD database to refresh and review validations is not immediate, which result in additional administrative actions for the insurer to review if the returned error has been resolved or simply due to a delay in the database clearing. We recommend SIRA consider any appropriate improvements to assist insurers in this regard and to minimise follow up administrative actions.*

In our view, the insurers have a legitimate interest in certainty and consistency in the information they have to provide to SIRA, and it is reasonable for them to think critically about the rationale for requests that they receive and with which they have to comply. However, we do not consider that it would be consistent with the intention of the Act to issue Guidelines that limit SIRA's ability to exercise its information-gathering powers as it sees fit. Moreover, it is not clear that this is appropriate subject matter for the Guidelines which, as a general proposition, place obligations on the insurers as opposed to SIRA, or on claimants where the Act specifically contemplates that the Guidelines will detail claimants' obligations.

For these reasons, we do not make any recommendation in light of the above submissions. However, we do assume that SIRA and the insurers will maintain an open dialogue about the intersection of SIRA's critical need to access data, and the insurer's legitimate interest in efficiency, certainty and consistency.

3.8.3 Approval of damages claim settlements by the PIC

Section 6.23(2)(b) prohibits the settlement of a damages claim where the claimant is not legally represented, unless the PIC approves the proposed settlement. We understand that SIRA monitors such settlements. The ALA submitted to us that this monitoring should include the rate at which the PIC rejects settlements as initially proposed.[221] We agree that this is clearly an important measure in the broader imperative to monitor insurers' conduct of damages claims by persons who are unrepresented. We assume that SIRA already does this monitoring or, if not, that it will adopt the ALA's proposal that it should do so.

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[220] Suncorp, *Submission to Review*, pages 16 - 17.

[221] ALA, *Submission to Review*, page 22.

3.8.4 Disclosure of information

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 SIRA can use the data to carry out its functions under the Act which include, among other things:[222]

- 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:
  - (a) the Act and the Guidelines, and
  - (b) 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:
  - (a) measures for preventing or minimising injuries from motor accidents, and
  - (b) safety education
- in relation to the provision of acute care, treatment, rehabilitation, long term support and other services for persons injured in motor accidents:
  - (a) to monitor those services
  - (b) to provide support and funding for programs that will assist effective injury management
  - (c) to provide support and funding for research and education in connection with those services that will assist effective injury management
  - (d) 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
- information obtained in the course of an investigation of an application for such a licence; or

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

- 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.

3.8.5 Publication of regulatory activities and outcomes

SIRA publishes information about its regulatory activities in the Scheme, notably on its *Motor accidents compliance and enforcement activity* web-page and in its regular *CTP Insurer Claims Experience and Customer Feedback Comparison* documents. SIRA states publicly that it has issued a 'regulatory notice' to an insurer (a 'notification of breach' or, under section 9.10 of the Act, a 'letter of censure') and the general topic to which the notice relates. SIRA also states publicly whether a 'remediation' plan has been opened or closed and whether an investigation is ongoing.

The ALA made a submission to the Law and Justice Review that SIRA should make more detailed disclosure of regulatory activities and outcomes. They wrote that:[223]

> *Although broad categories of areas of regulatory activities are mentioned, there is no specificity… The secrecy around SIRA's regulatory and enforcement actions is incredibly frustrating for those who seek transparent accountability for insurer conduct.*

SIRA has a publicly available compliance and enforcement policy.[224] It includes the following as one of the 'compliance and enforcement tools':

> ***Media releases***
>
> *SIRA may choose in the interests of transparency and public interests to release media content with respect to its activity. This may be conducted through SIRA's media or communications team and is not limited to any one particular medium. In assessing this tool, SIRA will have regard to the objectives of the compliance and enforcement policy in promoting our regulatory objectives.*

The Australian Securities and Investments Commission (**ASIC**), which is the federal regulator of, among other things, conduct by Australian financial services licensees, has a more detailed publicly available policy for public comment on its regulatory activities in its information sheet 'INFO 152'.[225] It includes the following statement:

> *We strive to ensure that financial consumers and investors have trust and confidence and can participate in fair and efficient markets, while being supported by efficient and accessible registration.*
>
> *We are accountable to Parliament and the public for our investigations, the regulatory actions arising from our investigations, and our general regulatory activities.*
>
> *Informing the public of our regulatory activities is important because it promotes:*

[223] ALA, *Submission to Law and Justice Review*, page 18.

[224] SIRA, *SIRA compliance and enforcement policy*, July 2017.

[225] ASIC, *Public comment on ASIC's regulatory activities* <https://asic.gov.au/about-asic/asic-investigations-and-enforcement/public-comment-on-asic-s-regulatory-activities/>.

- *public confidence in ASIC's administration of the law – that is, there is transparency around what we are doing about people who break the law*
- *compliance with the law by informing the public about the standards we expect and the consequences of failing to meet these standards.*

We agree that informing the public about regulatory activities promotes both public confidence in the regulator's administration of the law, and compliance with the law by the regulated population. We also agree that it is a manifestation of the regulator's accountability to the Parliament and to the public.

In light of the stakeholder feedback, we consider that SIRA could do more to make public the details about its regulatory activities and the conduct that is the focus of that activity. However, in our view the appropriate recommendation is for SIRA to develop and publicise its policy on informing the public about its regulatory activities and the rationale for its policy settings. This would provide an opportunity both for SIRA to review, consider and publicise its policy, and also for SIRA to allow stakeholders to better understand what they can expect of SIRA and, importantly, SIRA's policy position on transparency of its regulatory activities.

Recommendation 32

SIRA should develop and issue a public statement of its policy as to when it may comment publicly on its regulatory activities. SIRA's policy should include, among any other elements considered appropriate, its position on publication of the following, subject to circumstances in which it is against the public interest to do so:

(a) regulatory notices and letters of censure;

(b) civil penalties and other formal regulatory action, together with an outline of reasons for their imposition;

(c) an outline of any remediation plan opened in relation to a regulatory notice;

(d) the outcomes of any remediation plan opened in relation to a regulatory notice; and

(e) the outcome of any referral by the Independent Review Office to SIRA of a significant matter.

The policy should also address the circumstances in which SIRA may comment publicly, or will not comment publicly, on investigations.

***Rationale**: Informing the public of SIRA's regulatory activities is important because it promotes public confidence in SIRA's administration of the law, and compliance with the law by informing the public about the standards SIRA expects and the consequences of failing to meet those standards.*

3.8.6 Publishing information about insurer profit

One of the main aims of the reforms brought about by the Act was the Government's desire to reduce the proportion of CTP premium dollars retained by the insurers as profit. This is reflected in Objective (d) of the Act.

There is, not surprisingly, a significant degree of interest in the effectiveness of the Act in achieving this aim and it is recognised that the TEPL mechanism may have a role to play in order to achieve it, at least in respect of the early years of the Scheme. In its discussion about this, the Law and Justice Committee's '2020 Review of the Compulsory Third Party insurance scheme' report, published in July 2021, (**Law and Justice Report**) stated:[226]

> *Legal stakeholders all agreed that greater transparency regarding what the expectations were when the premiums were set and how those expectations are tracking now is required.*

[226] Law and Justice Report, page 16.

In part, the stakeholder submissions being referred to in the Law and Justice Report seemed to misunderstand the role of assumptions published by SIRA for the purposes of premium calculation. Some stakeholders took issue with SIRA updating assumptions to reflect actual experience, expressing dissatisfaction that it can be difficult to understand the extent to which previous assumptions used in earlier premium calculations have diverged from the subsequent experience in the Scheme. However, it seems clear to us that assumptions underlying current premiums should be as up-to-date as possible in respect of actual experience.

The real concern of stakeholders, as we understand it, is to understand how insurer profits are tracking in respect of premiums collected in the earliest years of the Scheme. If the claims assumptions underlying those premiums diverge from the subsequent experience, then profit may be substantially different from the profit assumptions underlying those premiums.

Under the TEPL Guidelines and under section 2.25 of the Act, SIRA will be undertaking annual assessments of projected average underwriting profit in the Scheme.

This issue was a particular focus of the Law and Justice Report, which recommended that our Review "closely consider … how to improve transparency and accountability in relation to insurer profits and premium setting."[227]

Stakeholder feedback is characterised by a general lack of knowledge about projected profit levels. Moreover, there is feedback of stakeholder frustration about a perceived lack of transparency. Our recommendation aims to address this second issue. We make no recommendation about specifically what information SIRA should disclose or when it should be disclosed. We consider that it is appropriate for SIRA to formulate its position in this respect.

Recommendation 33

SIRA should develop and issue a public statement of its policy for the publication of information about assessment of insurer profit under the TEPL Guidelines and section 2.25 of the Act (including information about insurer profit and SIRA's decision-making), as well as information about the application of clause 8 ('Innovation Support') of the TEPL Guidelines.

Rationale*: The Scheme would benefit if SIRA were to set expectations in relation to disclosure of insurer profits and the reasons for its position.*

[227] Law and Justice Report, Recommendation 1.

3.9 Minor injury

3.9.1 Introduction

The 'minor injury' framework applies to persons whose only injuries resulting from the motor accident concerned are 'minor injuries'. For such persons:

- access to statutory benefits for treatment is limited after 26 weeks by a more restrictive test than the 'reasonable and necessary' test that otherwise applies. Essentially, the test is no longer 'reasonable and necessary' treatment and care, but treatment and care if it is in one of the categories identified in clause 5.16 of the Guidelines and will improve the injured person's recovery or their capacity to return to work and/or usual activities;
- weekly payments of statutory benefits (i.e. income replacement payments) are not available after 26 weeks; and
- there is no entitlement to an award of damages (i.e. even for those injured through the fault of another driver).

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.

3.9.2 The purposes of the 'minor injury' framework

The 'minor injury' framework has two clear purposes. One purpose is to keep premiums affordable by limiting the benefits payable for 'minor injuries'.[228] The other purpose is to deter fraud and exaggeration in claims, by reducing the scope to make small claims for lump-sum compensation for soft tissue and relatively

[228] Section 1.3(2)(d) of the Act: Objective (d).

minor psychological injuries.[229] SIRA considers that the 'minor injury' framework "has successfully reduced the ability for people to abuse the system".[230]

These purposes correspond to the Act's Objectives (d) and (f), respectively. In the case of Objective (d), advancement of the Objective comes:

- potentially at the expense of treatment and care and income support for some injured persons; and
- at the expense of compensation for loss suffered by persons who are injured through the fault of another person, where the law would otherwise entitle such persons to compensation.

This is how the 'minor injury' framework manifests one of the reform aims that underpinned development of the Scheme, which was to ensure that a higher proportion of benefits went to the most seriously injured.

In the case of Objective (f), advancement of the Objective comes at the expense of compensation for loss suffered by persons who are injured through the fault of another person, where the law would otherwise entitle such persons to compensation.

As we discuss below, it is important to keep this in mind when reviewing the 'minor injury' framework against the Act's Objectives. We note also our comments at the start of this report regarding striking the right balance between the Objectives.

3.9.3 Another purpose of the 'minor injury' framework?

In the Minor Injury Review, SIRA stated that the 'minor injury' framework was introduced to give people injured in accidents "fast access to statutory benefits" in the form of weekly income support and medical treatment and care; to give injured people better payments faster so that they can focus on rehabilitation and return to good health.

We do not accept that this is a purpose of the 'minor injury' framework, or that the framework facilitates the speed of access to benefits. In our opinion, the 'minor injury' framework simply reduces and removes entitlements to benefits.

In its submission to the Review on behalf of the insurers, the ICA had a similar point of view to that of SIRA:[231]

> *The minor injury definition and the 26-week statutory benefit period provides for greater focus on recovery and supports the timely resolution of minor injury claims, thereby reducing the length of time that an injured person needs to spend in the Scheme.*

We do not agree. There is no element of the 'minor injury' framework that increases or facilitates a greater focus on recovery. Further, the framework "supports the timely resolution of minor injury claims" only in the sense that it mandates their closure in respect of income support at 26 weeks, limits access to treatment and care after 26 weeks, and prevents a damages claim. It does not reduce the length of time that an injured person "***needs*** to spend in the Scheme"; it reduces the length of time that an injured person is ***allowed*** to spend in the Scheme.

If there is a way in which the 'minor injury' framework might be said to support injured persons to "focus on recovery", then this could only relate to the withdrawal or restriction of access to statutory benefits. It would rely on the proposition that injured persons will benefit from having their ongoing support removed, so that they will be encouraged to stop being injured and return to work instead. We are not aware of any support

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

[230] SIRA, *Submission to Law and Justice Review*, page 18.

[231] ICA, *Submission to Review*, page 11.

for this. When we put the proposition to the Medical and Allied Health forum that was convened in the course of the Review, it received no support.

The reason that the asserted "focus on recovery" advantage to injured persons could only relate to statutory benefits – and not the removal of damages claims – is because the early and ongoing support provided by statutory benefits would already address, in cases of relatively minor injury, any concern about the health effects of compensation claims. The 'minor injury' definition aims to capture injuries that are expected to resolve in 6 months.[232] In the Minor Injury Review, SIRA reported that 98% of earners with only 'minor injuries' had returned to work by 52 weeks. If almost everyone with only 'minor injuries' has recovered by 52 weeks, then a damages claim made after 52 weeks by a person with only minor injuries would, in almost every case, be a claim for *past* economic loss only, by a person who has already recovered and completed a statutory benefits claim. Such claimants do not need support to "focus on recovery". They have already recovered.

3.9.4 Reviewing the 'minor injury' framework

We make these observations because it is essential, when reviewing the 'minor injury' framework against the Act's Objectives, to have a clear understanding of the Objectives that it aims to advance. The intention of the framework is to advance the interests of purchasers of CTP policies by keeping premiums affordable, and not to advance the interests of injured persons. That it is a legitimate intention and in accordance with Objective (d). However, it means that assessment of the framework has to focus on the balance of affordability of premiums and validity of claims with the support that the Scheme provides to injured persons to advance Objectives (a) and (b).

The task of reviewing the 'minor injury' framework has, as its central element, to review whether the settings of the framework are appropriate to minimise the detrimental effect on injured persons while still advancing the Objectives that the framework is intended to advance. To review the 'minor injury' definition, one needs to recognise that it is there not to provide support but to exclude people from support. One does not only look at the cases of injured persons to whom the Scheme provided the treatment, care and financial support that they needed; those persons receive the support they need *despite* the 'minor injury' framework. Rather, one must look at the persons who have been *excluded* from getting the treatment, care and financial support that they need. If there are only a few of those persons, or they are doing well despite their exclusion from 'reasonable and necessary' treatment and care, or the shortfall in financial support for lost income was only slight, then it may be possible to conclude that the 'minor injury' framework is appropriately balanced.

In other words, the task is to consider and find the right balance between Objectives directed to different outcomes. In relation to the exclusion of damages, this means ensuring that the framework avoids capturing injured persons whose injuries are so serious that they are in a cohort that the Act otherwise recognises ought to be allowed to claim damages. This could primarily arise if persons who would otherwise be entitled to claim damages for non-economic loss (i.e. damages for pain, suffering, loss of amenities or loss of expectation of life) – because their degree of permanent impairment is greater than 10% – are prevented from doing so because they are captured by the 'minor injury' definition.

In relation to statutory benefits, the criterion for the analysis is less clear because it involves an evaluation as to whether too many injured persons are being cut off from treatment and care or income support before it is appropriate for that to happen.

The 'minor injury' definition is designed to capture injuries that should resolve within 6 months.[233] A curiosity of the regime to remove or reduce statutory benefits at 6 months is that, if the 'minor injury' definition were calibrated perfectly to achieve its intention to capture only injuries that should resolve within 6 months, there would be no need for provisions in the Act cutting off or reducing benefits at that point. Persons with only

[232] SIRA, *Minor Injury Review*, page 8.

[233] Ibid.

'minor injuries' would have recovered and no longer need statutory benefits anyway. The framework could then simply provide that persons with only 'minor injuries' have no entitlement to damages.

In this light, it is apparent that the reason the Act contains provisions cutting off or reducing statutory benefits at 6 months is *because* the 'minor injury' definition will do its work imperfectly. Some injured persons will lose support that they actually still need.

When we spoke with medical and allied health professionals in the course of the Review, their feedback was to the effect that the prognosis for those with 'minor injuries' is heterogeneous; some individuals with only 'minor injuries' will have a high risk of poor recovery, while others will have only a low risk of poor recovery. On one view, the Act recognises this, or more specifically that not all persons with only 'minor injuries' will be fully recovered at 26 weeks, despite the aim of the definition. The intention of the Act is generally to exclude those persons from financial support after 26 weeks and to exclude treatment and care if recovery is not improving.

It is important to consider whether some of those persons may not in fact be persons from whom it is appropriate that the 'minor injury' framework withdraws support in the advancement of Objectives (d) and (f).

Content of the 'minor injury' definition

We received specific submissions from medical and allied health stakeholders to the effect that certain medical conditions that currently are captured by the definition of 'minor injury', should not be captured by it.[234] When we spoke with medical and allied health organisations at a forum convened by SIRA, several of the representatives, in their opening remarks, said that they specifically wanted the definition of 'minor injury' to be the subject of consideration.

Subject to the discussion below about adjustment disorder (a psychiatric diagnosis), we were not in a position in our Review to review the definition of 'minor injury' from a technical point of view.

The Law Society of NSW advocates for a change to the definition of 'minor injury' so that it incorporates a "narrative test":[235]

> *a 'narrative test' should be developed, which includes objective evidence of physical and/or psychological injury, but that does not rely solely on a number (for example, a WPI percentage). Instead, such a test should also consider the consequences of the injury on a person, and contain elements to the effect of:*
>
> > *"A permanent reduction in physical, psychosensory or intellectual potential that is the result of an anatomo-physiological injury:*
> >
> > *(a) that can be detected medically and can therefore be assessed on the basis of appropriate clinical testing, supplemented by a study of additional tests furnished (e.g. MRI, x-ray, CT scan, etc), and*
> >
> > *(b) that is compounded by pain phenomena and psychological impacts or ordinarily associated with the sequelae described, as well as consequences in everyday life that are customarily and objectively associated with such injury."*

Osteopathy Australia also advocates for amendments to the 'minor injury' definition, specifically in relation to psychological injuries, so that it operates having regard to:[236]

> *their impact on client affect, attitude and function, diagnostic label notwithstanding. This change would support the growing number of clients with pain conditions and psychological symptoms that may not be able to be clearly fitted into a diagnostic box but are crucial to manage in recovery.*

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[234] Osteopathy Australia, *Submission to Review*; A Chesterfield Evans, *Submission to Review*.

[235] Law Society of NSW, *Submission to Review*, page 6.

[236] Osteopathy Australia, *Submission to Review*, page 7.

For our part, we are disinclined to support a change of this kind because it could risk defeating what we understand to be the intention of the current approach, which is to have a definition that can be readily applied based on the treating practitioner's diagnosis of the person's injuries. We are aware that this approach presents difficulties, because the medical diagnosis alone is arguably not a good indicator of the prognosis for recovery. However, the approach we have taken in relation to 'minor injury' is to make recommendations that may enable the current approach to work better.

We assume that SIRA will undertake another review of the minor injury definition. Submissions to this Review certainly indicate that stakeholders consider it to be necessary. When it undertakes the next review, we trust that SIRA will have the benefit of the discussion in this Review to assist its work to ascertain both: (i) whether it is achieving its aims, and (ii) whether it is appropriately balanced against the needs of injured persons who are affected by it.

3.9.5 Adjustment disorder

The definition of 'minor injury' includes the psychiatric diagnosis, 'adjustment disorder'. Adjustment disorder is a medical diagnosis based on observed symptoms and the presence of a 'stressor' underlying the disorder. One of the criteria for the diagnosis is that the condition is resolved within 6 months after the stressor is removed. It does not follow that an injured person's condition diagnosed as adjustment disorder will resolve within 6 months after the motor accident concerned. We explain this below.

Prior to commencement of the Scheme, it was recognised by stakeholders including SIRA that there was an issue associated with adjustment disorder, because a diagnosis by 13 weeks does not mean that the person's condition will have resolved or even necessarily improved at 26 weeks. Rather, it may mean only that the diagnosis will change after 26 weeks.

Several stakeholders have raised concerns about adjustment disorder in submissions both to the Law and Justice Review and to our Review. We discussed the matter with medical and allied health stakeholders during the course of the Review. SIRA has stated that this Review presents an opportunity to consider the merits of a change.[237]

The position is as follows:

1. Persons injured in a motor accident may develop symptoms diagnosed as adjustment disorder as a result of the accident.
2. If the symptoms that result from the motor accident persist beyond 6 months after the event, then it follows that either:
    (a) the relevant 'stressor' is not (or is not only) the event that occurred on the day of the motor accident, and instead may be, for example, the injury or quality-of-life changes that resulted from the accident; or
    (b) the diagnosis will change, because one of the criteria for the 'adjustment disorder' diagnosis is not satisfied (i.e. the criterion that the condition resolves within 6 months after the stressor is removed).
3. In either of scenarios (1) or (2) above, the injury is not one that the 'minor injury' framework is intended to capture. The condition is ongoing.
4. If the injured person's condition resolves within 6 months after the motor accident concerned, then the 'adjustment disorder' diagnosis can stand. However, there is no imperative to apply the 'minor injury' framework to that injury so as to cut off financial support to the injured person. This is

[237] SIRA, *SIRA's answers to questions taken on notice at the Law and Justice Committee's 2020 Review of the Compulsory Third Party Insurance and Lifetime Care and Support schemes (CTP and LTCS) hearing – 26 May 2021*, page 13.

because, as the condition is resolved, it will not be a basis for any claim to ongoing financial support in any event.

5. For the above reasons, the mere fact of a diagnosis of 'adjustment disorder' in place at 13 weeks after the motor accident concerned provides no basis to conclude that treatment and care, and financial support, will no longer be required after 26 weeks. Where the diagnosis at 13 weeks is 'adjustment disorder', all that can be said is that the underlying condition may or may not be resolved by 26 weeks.

One effect of removing 'adjustment disorder' from the definition of 'minor injury' is that, in scenario (4) above, the injured person whose condition resolved within 6 months will be entitled to claim damages if another person was at fault. However, there are any number of non-'minor injuries' that can and do resolve within 6 months and leave open a claim for damages, and 'adjustment disorder' would simply be one such condition. This is appropriate given point (5) above.

In our view it is not appropriate for injured persons with a diagnosis of 'adjustment disorder' to receive a notice from the relevant insurer at 13 weeks stating that their financial support will be cut off at 26 weeks because they are within the definition of 'minor injury', in circumstances where it is known that the diagnosis does not justify the conclusion that the condition will be resolved by that time. From the point of view of ensuring that a claimant's experience in the Scheme is one that assists recovery and does not exacerbate the stress resulting from the injury and its effects on quality of life, an injured person in that situation should not have to approach the insurer with an updated diagnosis applied after 26 weeks and ask to be allowed back into the Scheme.

Further, for any injured person with 'adjustment disorder' where the underlying stressor is not limited to the event of the motor accident itself, they are currently excluded from support after 26 weeks in circumstances that defeat the policy intent of the Scheme because their condition – fully consistent with the 'adjustment disorder' diagnosis – is ongoing beyond 26 weeks.

Recommendation 34

The Minister consider the making of an amendment to the regulations to remove 'adjustment disorder' from the definition of 'minor injury'.

***Rationale**: The definition of 'minor injury' must only include conditions that are expected, with appropriate treatment and care, to resolve within 6 months after the motor accident concerned.*

3.9.6 Diagnostic imaging

Clauses 5.3 and 5.4 of the Guidelines are made under section 1.6(5) of the Act and concern the assessment of whether a person's injuries are 'minor injuries'. They read as follows:

> 5.3 The assessment will determine whether the injury related to the claim is a soft tissue injury or a minor psychological or psychiatric injury caused by the motor accident.
>
> 5.4 Diagnostic imaging is not considered necessary to assess minor injury.

The above provisions do not concern treatment and care, and in particular they do not prescribe whether diagnostic imaging ordered by a treating practitioner is 'reasonable and necessary' for the purposes of an injured person's entitlement to statutory benefits.

However, feedback to the Review indicates that clause 5.4 has been relied on by insurers to deny treatment and care benefits for imaging ordered by practitioners who are treating 'minor injuries'. Although this is an issue with implementation of the Guidelines by insurers, it appears to arise from a lack of clarity in the drafting of clause 5.3 and this should be corrected. The drafting of the provision should be such that it is clear to laypersons and lawyers alike that it concerns the 'minor injury' decision only, and does not provide a basis to decline treatment and care requested by a treating practitioner.

Recommendation 35

SIRA should amend clause 5.4 of the Guidelines for clarity, so that the clause reads: *Insurers should not require injured persons to undergo diagnostic imaging for the purpose of the insurer determining whether the injury related to the claim is a minor injury.*

***Rationale**: Claim managers should be supported to understand correctly the restriction on the use of diagnostic imaging.*

3.9.7 'Minor injury' and permanent impairment

If a person has only 'minor injuries', after 26 weeks they are no longer entitled to statutory benefits for treatment and care that is reasonable and necessary. Rather, there are two key criteria for the entitlement to ongoing treatment and care. First, the treatment and care must be in one of the following categories (listed in clause 5.16 of the Guidelines):

(a) medical treatment, including pharmaceuticals

(b) dental treatment

(c) rehabilitation

(d) aids and appliances

(e) education and vocational training

(f) home and transport modifications

(g) workplace and educational facility modifications

Second, the treatment and care must be expected to ***improve their recovery or their capacity to return*** to work and/or usual activities.[238]

By design, the 'minor injury' framework contemplates that there will be persons with only 'minor injuries' who need reasonable and necessary treatment and care after 26 weeks, but who will not be able to access that support within the Scheme. These are persons who need further treatment and care to relieve symptoms or to maintain their health status but whose recovery, or capacity to return to work or other activities, is ***not expected to improve*** with that treatment and care.

We received feedback from some stakeholders, including medical and allied health organisations, that the Scheme should provide treatment and care support to such persons. That is an understandable position because it reflects both compassion for injured persons and the focus of medical and allied health practitioners to continue appropriate treatment and care to address whatever are the medical or health needs of an injured person. The exclusion of treatment and care after 26 weeks for persons for whom that treatment and care is reasonable and necessary, but only for the purpose of maintaining health status or managing symptoms, is a design feature of the Scheme. However, like all aspects of the 'minor injury' framework it should be the subject of analysis and review. In our view an analysis of this feature would need to be informed by the frequency with which the 26 weeks limitation impacts persons in the category described above and the severity of the ongoing symptoms of affected persons. We are not in a position to do that analysis. We are also not aware that the analysis has been done by SIRA or others.

The fact that the 'minor injury' framework specifically contemplates that some persons with only 'minor injuries' will have injuries that subsist even after treatment and care no longer aids improvement, leads to a consideration of the degree of permanent impairment of those persons. The damages aspect of the Scheme manifests a clear intention that injured persons with a degree of permanent impairment greater than 10% as a result of injuries caused by the fault of another driver should be entitled to claim damages, including

[238] Clause 5.16 of the Guidelines also provides that treatment and care in these categories may continue after 26 weeks if the insurer delayed approval for the treatment and care expenses.

damages for pain, suffering, loss of amenities or loss of expectation of life (i.e. damages for non-economic loss).

From submissions to the Review we understand that it is possible (though presumably unusual) for a person to have multiple 'minor injuries' (and no injuries which are not 'minor injuries') but permanent impairment greater than 10%. For injured persons in that situation, there is an anomaly in the Scheme, in that: (i) it is recognised that permanent impairment greater than 10% justifies the award of damages for non-economic loss, but (ii) a person with permanent impairment greater than 10% cannot claim damages if the injuries having that result are exclusively 'minor injuries'.

This is an anomaly because those persons clearly fit within the rationale for the framework for damages for non-economic loss, but in respect of permanent impairment do not fit within the rationale for the 'minor injury' framework (which generally is intended to apply to conditions that resolve within 6 months and, for persons with ongoing injuries, is not intended to capture serious injuries[239]).

In our view, this should be corrected by allowing the injured persons in the unusual situation of having 'minor injuries' only, but permanent impairment greater than 10% as a result of injuries cause by the fault of another driver, to claim damages. Except to this extent, such persons should otherwise remain within the 'minor injury' framework because the assessment of permanent impairment is not likely to be made before the end of the statutory benefits period for minor injuries. That is, statutory benefits should cease or reduce in line with the 'minor injury' framework, but if permanent impairment is later assessed at greater than 10%, they should be entitled to lodge a claim for damages if another person was at fault.

Recommendation 36

The legislature consider amending the Act to provide that all injured persons may claim damages if the injuries caused by the motor accident result in a degree of permanent impairment greater than 10%.

***Rationale**: The Scheme should give all seriously injured persons (with a degree of permanent impairment greater than 10%) a right to claim damages for ongoing pain, suffering, loss of amenities or loss of expectation of life.*

3.9.8 The 'minor injury' statutory benefits time limit

The purpose of the minor injury framework is to limit opportunities and incentives for fraud and to limit benefits in order to help the affordability of CTP premiums.

These purposes are addressed primarily by the removal of access to damages (i.e. lump-sum compensation). In relation to fraud, the concern is to avoid the availability of relatively small lump-sum compensation payments (for the cost of both health care and lost income), which under the 1999 Scheme was understood to create opportunities and incentives for 'staged' accidents or exaggerated, minor claims. The removal of the right to damages for persons with only 'minor injuries' addresses this – it means that persons with 'minor injuries' are only compensated for services actually rendered by health professionals, and lost income is compensated by defined, ongoing weekly payments in respect of work capacity that requires ongoing certification.

In relation to affordability, our understanding is that the significant reduction in cost to the Scheme is in the absence of damages payouts for 'minor injuries' (rather than the reduction in statutory benefits payments). However, there is an additional and important point about how the affordability objective is achieved. The 'minor injury' definition is intended to capture injuries that should resolve within the period of full entitlement to statutory benefits. It follows that the Scheme does *not* intend to reduce costs and increase affordability by cutting off statutory benefits. If it were intended to reduce costs and increase affordability by cutting off

[239] The Act specifically states a "clear legislative intention to restrict access to non-economic loss compensation to serious injuries" (section 1.3(3)(b)), and it follows that the Act's concept of "severe injury" is satisfied if the degree of permanent impairment is greater than 10% because that is the criterion on which the restriction is put into effect.

statutory benefits, then the 'minor injury' definition would have to be framed in such a way as to capture injuries deliberately that are not expected to resolve within 6 months.

With this understanding of the way that the 'minor injury' framework seeks to achieve its aims, there is then the question as to how restricting access to statutory benefits for treatment and care after 6 months, and removing any entitlement to weekly payments after 6 months, advances those aims.

In the case of treatment and care, the position is clear. The 'minor injury' framework seeks to reduce costs to the Scheme by ensuring that persons with ongoing injuries, who benefit from treatment and care but where the injury has stopped improving and is relatively minor, are removed from the Scheme. Understandably, this is a design feature that was not favoured by medical and allied healthcare organisations in feedback to the Review. Nevertheless, it is a design feature that the Parliament decided to include. The number of affected persons and the severity of those persons' ongoing injuries should remain under review to ensure that the balance in the Scheme is appropriate. This should form a part of any future review of the 'minor injury' framework.

In the case of weekly payments (i.e. income support), the position is less clear. The Scheme does not aim to reduce costs by cutting off weekly payments to earners who have not yet returned to work and were injured in a motor accident caused by the fault of another person. This means that the intended benefit to the Scheme must relate to the deterrence of fraud, or perhaps exaggeration of claims to avoid return to work and collect weekly payments instead.

We doubt whether the 26-week cut-off for weekly payments is a significant deterrence for fraud or claim exaggeration, particularly having regard to the fact that the aspect of the 'minor injury' framework that primarily aims to deter fraud is the absence of entitlement to pay damages. Furthermore, weekly payments require re-certification of lack of fitness for work every 28 days[240] and cannot be claimed prospectively as a lump-sum payment.[241] Accepting, though, that the 26-week cut-off makes some contribution, it is relevant to note that, in the Minor Injury Review, SIRA reported that 24% of earners with only 'minor injuries' had neither "a status of 'returned to work' or … a specific return to work date" at 26 weeks when weekly payments were stopped.[242] Given that most claims in the Scheme are 'minor injury' claims, this represents a significant number of injured earners who had not returned to work and required ongoing income support, but whose income support was nevertheless cut off. *All* of the affected persons in these figures were injured through the fault of another person.

In our view, the appropriate conclusion on this analysis is that the timeframe for ongoing weekly payments for persons with only 'minor injuries' should be extended. When it is understood that the design of the 'minor injury' framework aims not to affect injured people in this way at all, we consider that there is an inappropriately large number of injured persons who are being affected.

In the Minor Injury Review, SIRA reported that the average additional duration of treatment and care claims that extend past 26 weeks is 10 weeks (which indicates that, on average, injuries that continued to improve with treatment and care past 26 weeks stopped improving by 36 weeks).[243] We assume that there is a significant overlap between persons who have injuries that are still improving with treatment and care and earners who have not fully returned to work. Only 2% of 'minor injury' treatment and care claims remained open at 52 weeks after the motor accident.[244] We conclude that 52 weeks would evidently be a more appropriate timeframe for the period of entitlement to statutory benefits.

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[240] Section 3.15(1)(a) of the Act.

[241] Section 3.42 of the Act.

[242] SIRA, *Minor Injury Review*, page 27.

[243] Ibid, page 22.

[244] Ibid, page 20.

As a separate consideration, we observe that the Minor Injury Review discussed issues relating to the identification within the required timeframe (currently 13 weeks) of psychological and psychiatric injuries that are 'minor injuries'. Feedback to the Review indicates that this remains a concern, and that the handling of these claims could improve if there were a longer timeframe in which to make the necessary assessment.

Finally, we acknowledge the concern expressed by SIRA in the Minor Injury Review, that extending the period of full entitlement to statutory benefits could be detrimental to health outcomes for injured persons who would access those statutory benefits (specifically, "that staying in a personal injury compensation scheme for a longer period of time can have detrimental effects on an injured person's recovery and general wellbeing").[245] The concern arises from research into the association between health outcomes and prosecution of damages claims. However, what we are considering here is extending injured persons' entitlement to ongoing statutory benefits from 26 weeks to 52 weeks, in circumstances where those persons have not returned to work at 26 weeks, require ongoing treatment and care, and have an established statutory benefits claim. We are not aware of research that supports a conclusion that the effect on health outcomes for those persons would be negative. The ongoing conduct of an established statutory benefits claim between the 26th and 52nd weeks seems to us to be entirely unlike the conduct of a claim for damages. If that is right, then research about the conduct of a damages claim cannot be brought to bear on consideration of the effect of extending a statutory benefits claim from 26 to 52 weeks.

SIRA's conclusion in the Minor Injury Review on extending the period of entitlement to statutory benefits was:[246]

> *SIRA does not consider extending the scheme threshold past 26 weeks best supports injured people and is more likely to be detrimental to recovery. The data on injured people accessing treatment and care after 26 weeks indicates that existing mechanisms under the Act are currently providing adequate support.*

For reasons we have explained, we are not aware of research to support the concern about detriment to recovery, and we do not agree that data on injured people who are *accessing* treatment and care because their treatment and care is *not* excluded by the 'minor injury' framework can, by itself, support a conclusion that the framework allows for adequate support.

An extension to 52 weeks may have some impact on affordability. However, we consider that this is an appropriate design setting for the Scheme to achieve the right balance between the Objectives.

Recommendation 37

The legislature consider amending sections 3.11 and 3.28 in Part 3 of the Act to extend to 52 weeks the current 26-period of statutory benefits for persons with minor injuries only.

***Rationale**: The minor injury framework requires refinement to ensure that it applies to injured persons in the way that the Scheme intends.*

3.9.9 The term 'minor injury'

In the Minor Injury Review, SIRA wrote:[247]

> *Insurers provided anecdotal feedback to SIRA that there were injured persons who were unhappy with the term 'minor injury' and the perception that their injury was 'minor'. Insurers also indicated that the use of the term 'minor' made it difficult to communicate with injured people due to 'negative connotations'. Further, it*

[245] SIRA, *Minor Injury Review*, page 26.

[246] Ibid.

[247] Ibid, page 31.

was reported that the use of the term 'minor' is driving some people to have their claim reviewed as they do not perceive their injury to be minor.

This continues to be a concern, as we explain in some detail in Appendix A to this Report. We received feedback from a wide variety of stakeholders that the term 'minor injury' is unsatisfactory, because it is offensive to injured persons whose injuries have a significant impact on them, and because it has no necessary connection with health practitioners' assessment of an injured person's prognosis. We can readily accept that the term 'minor injury' can be understood by injured persons to trivialise their injury and the impact on their lives, and that allowing this can cause distress which is both unnecessary and potentially detrimental to certain injured persons.

The ALA and the Law Society of NSW, while acknowledging the issues associated with the terminology, consider that the term 'minor injury' has become familiar to stakeholders and make the point that changing the term may lead to greater confusion and adverse consequences.[248] With respect, we do not agree. If the term is changed, the injured persons who claim after that date are unlikely to know anything other than the new definition and ought not to be confused. There will necessarily be an adjustment for the stakeholders who are engaged on an ongoing basis in the Scheme (including insurers, the medical and allied health profession, and lawyers). However, change of terminology in legislation is not without precedent, does not present insurmountable challenges and in our view the benefit (the well-being of injured persons) outweighs the potential difficulties of replacing a familiar term. We recommend that the term 'minor injury' be changed.

The suggestion in our Discussion Paper – 'short-term benefits injury' – received little support. A range of other terms were suggested, such as 'self-limiting injury' or 'short-term recovery injury' or descriptors for benefits such as 'Category A/Category B'. We consider that SIRA should consult with relevant stakeholders to identify a term that is neutral as to its characterisation of the injuries which impact injured persons.

Recommendation 38

SIRA should undertake a consultation to identify an alternative term for 'minor injury', with a view to proposing that the term be changed.

***Rationale**: The term 'minor injury' is not appropriate to describe what, for many injured persons, are significant injuries.*

3.9.10 Reversal of a 'minor injury' decision

The 'minor injury' framework acts as a gateway to damages.[249] If an insurer makes a decision that a claimant has only 'minor injuries' and applies the restrictions on statutory benefits accordingly, then it follows that the insurer would say that the claimant is also not entitled to any damages. If the claimant lodges a dispute about the insurer's decision in the PIC, the outcome will be a binding determination by a medical assessor. If the outcome of the medical assessment matches the insurer's decision, then the claimant will have no claim for damages.

In many cases of an insurer's decision that a claimant's injury is a 'minor injury', we would expect that the injured person will accept the decision, not dispute it in the PIC and not lodge any claim for damages.

However, even if the injured person did not dispute the insurer's decision, they would still be entitled later to lodge a claim for damages if they wished, and it would be a matter for the insurer to defend it on the basis that the claimant's injury is a 'minor injury'. Ultimately, the matter would be decided by the binding determination of the 'minor injury' decision by a PIC medical assessor. If the claimant were successful in this, the damages claim could proceed; if not successful, the damages claim would end there.

[248] ALA, *Submission to Review*, page 4; Law Society of NSW, *Submission to Review*, page 5.

[249] Section 4.4 of the Act.

What about the case where the insurer accepted in the course of the statutory benefits claim that the claimant had an injury that was not a 'minor injury', but later when the claimant lodges a claim for damages, the insurer wishes to reverse its decision and defend the damages claim on the basis that the claimant's injury is a 'minor injury' (and apply the 'minor injury' framework to the statutory benefits claim)? This was raised as a concern in submissions to the Review.[250]

In cases such as these, the 'minor injury' issue would not have been the subject of a binding determination. There is an argument that there should come a point where the insurer should lose the right to reverse its decision; perhaps on the basis that, after a reasonable time, the insurer's decision should serve as an admission that the claimant has an injury that is not 'minor'. However, in our view this argument is flawed. It would not be an appropriate mechanism in the Scheme.

The onus on insurers to prove 'minor injury'

The reason for our view is that the onus is on the insurer to establish its entitlement to stop paying statutory benefits to an injured person on the basis that they have only a 'minor injury'. This means that the insurer may only apply the 'minor injury' framework if it can prove with evidence that the claimant's injury is a 'minor injury'. If the insurer does not positively form the view, based on evidence, that the injury is a 'minor injury', then it must not apply the 'minor injury' framework to the injured person's claim. The corollary of this is that the insurer does not need to make any positive decision that a claimant has an injury that is not a 'minor injury'.

In short, if the insurer keeps open a statutory benefits claim past 26 weeks, this does not necessarily entail any positive decision that the claimant's injury is not a 'minor injury'. This would only be the case if the onus were on a *claimant* to prove that there injury was *not* a 'minor injury'. Claimants do not – and in our view should not – bear that onus.

As an aside in this discussion, we received feedback from some stakeholders to the effect that insurers do not always apply the onus in relation to 'minor injury' correctly; that they sometimes adopt a position of requiring injured persons to establish with evidence that they have an injury that is not a 'minor injury'. If that occurs, it is an incorrect implementation of the 'minor injury' framework. We recommend that SIRA should include analysis of this issue in the independent file reviews recommended by Deloitte, so that it can understand how frequently this occurs and take steps to address it. This comment also applies to establishing fault and contributory negligence in statutory benefits claims – although later in this report we recommend that the Government consider removing the issue of fault from statutory benefits claims altogether (see Recommendation 40).

Reversal of the insurer's position

Nevertheless, in our view an injured person whose statutory benefits claim proceeds on the basis that their injury is not a 'minor injury' should be protected from a situation where, if a significant time has passed since the motor accident and they are considering lodging a claim for damages or they do in fact lodge such a claim, the insurer changes its position and decides that the person's injury is a 'minor injury'. Absent protection, this would lead to the injured person's statutory benefits being stopped.

We recommend that, if more than 18 months have passed since the motor accident concerned and the statutory benefits claim has been treated as a non-'minor injury' claim, the insurer must not apply the 'minor injury' framework to the claim without first getting a binding, independent determination of the matter. We have reached this conclusion for the following reasons.

First, such a decision has the potential to affect adversely an injured person's treatment and care and financial support at a time when they might be entitled to think that the issue had been settled.

Second, 'minor injury' decisions are 'medical assessment matters' which, according to the feedback we received from some stakeholders, insurers may not necessarily always be well-placed to make.

[250] ALA, *Submission to Review,* page 7; Stephen Young Lawyers, *Submission to Review*, page 4.

Third, because a late, adverse decision on 'minor injury' is most likely to arise in the context of a damages claim, it would arguably be inappropriate to allow the insurer's decision to take effect otherwise than as a result of an authoritative, independent decision by a medical assessor.

Fourth, for injured persons still requiring treatment and care or income support at 18 months, the 'minor injury' framework is not intended, in a broad sense, to affect that support because the framework is targeted at injuries that will in fact resolve or stop improving with treatment at 6 months and not prevent the injured person from returning to work at 6 months.

Recommendation 39

The legislature consider amending the Act to provide that, in circumstances where an insurer wishes to reverse its decision – adversely to the claimant – as to whether the injuries caused by the motor accident are minor injuries exclusively for the purposes of Part 3 of the Act (Statutory benefits), and more than 18 months have passed since the motor accident concerned, the insurer must refer the matter to the Commission for medical assessment and must not cease paying statutory benefits (unless otherwise permitted to do so under the provisions of the Act) until such time as a medical assessor issues a certificate as to the matter, to the effect that the claimant's injuries are minor injuries exclusively.

Rationale*: Insurers should be able to change their decisions in light of new evidence, but in some cases a new decision should be confirmed by someone independent.*

3.10 Injured persons who are at fault

3.10.1 Introduction

The Act provides that statutory benefits 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.[251] An accident is taken to have been caused mostly by a person's fault if the person's contributory negligence was greater than 61%.[252]

For a person who was not 'wholly or mostly' at fault but whose negligence contributed to the accident, weekly benefits reduce after 26 weeks in proportion to the person's negligent contribution.[253]

This aspect of the Scheme necessarily limits achievement of Objectives (a) and (b), which itself does not distinguish between treatment and care required by persons who are, or are not, at fault. Arguably, it does not advance any of the Objectives in section 1.3(2) of the Act.

3.10.2 Extension of benefits to persons at fault

In submissions to the Law and Justice Review, the ICA and Suncorp supported extending statutory benefits for at-fault persons (with non-minor injuries) past 6 months.[254] The ICA suggested that this could be done by simply removing all limitations on statutory benefits for at-fault persons,[255] or extending the period of treatment and care benefits only.[256] In evidence given to the hearings of the Law and Justice Review, the NSW Bar Association appeared also to support extending statutory benefits for at-fault persons on the basis that it would be an inexpensive extension of the Scheme.[257]

The ICA's position was more circumspect in submissions to this Review:[258]

> *The question of entitlements provided by the Scheme to those who are considered at-fault in an accident is a matter for Government who must balance the cost to be borne by motorists, the amount of benefits that are distributed to the injured whilst ensuring that the balance is struck at a point that aligns with community values and expectations, all of which are acknowledged as changing over time.*
>
> *On the issue of 'fault' in the Scheme, Insurers note that the Scheme is beneficial in nature, that the injuries a person suffers in a motor accident are often not in proportion to their contribution to it and the impact of motor accident injury can be far broader than the individual.*
>
> *The Insurance Council and insurers have previously identified that the current scheme design can impact recovery of at-fault claimants that have sustained a non-minor injury and are open to expanding benefits for these claimants provided scheme sustainability can be maintained.*

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[251] Sections 3.11 and 3.28 of the Act.

[252] Ibid.

[253] Section 3.38(1) of the Act.

[254] ICA, *Supplementary Submission to Law and Justice Review*, page 2; Suncorp, *Submission to Law and Justice Review*, page 1.

[255] ICA, *Supplementary Submission to Law and Justice Review*, page 3.

[256] Ibid; see also Suncorp, *Submission to Law and Justice Review*, page 1.

[257] Law and Justice Review, *Hearing Transcript*, 25 May 2021, page 48 (Ms Welsh).

[258] ICA, *Submission to Review*, page 6.

> *There are many variables to consider in evaluating whether it is appropriate or desirable to reform the guiding principle to rationing Scheme benefits. Insurers consider this a matter for separate and detailed investigation and would gladly engage with Government and SIRA in the task.*

Suncorp's position is that, for non-'minor injury' claims:[259]

> *Statutory benefits for treatment and care and weekly benefits should be made available to all injured people regardless of fault for up to two years.*

The extension of availability of statutory benefits for at-fault persons received support in our consultation meeting with medical and allied health practitioners.

The ALA made the following submission:[260]

> *The ALA has no issue in principle with extending statutory benefits for treatment, care and lost wages out to 12 months subject to how it is paid for. If it is to be paid for by increasing premiums and making drivers more responsible for the damage they cause, then the ALA supports the premium increase. If it is to be paid for by further reducing insurer profits, then the ALA has no objection to that course either.*
>
> *However, if the extra six months of statutory benefits is to be paid for by (yet again) slashing away at the rights of those innocent motor accident victims entitled to fair compensation, then the ALA stands firmly against any such course.*

The Law Society of NSW does not support extending at-fault statutory benefits:[261]

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

The Law Society of NSW had additional arguments against extending at-fault statutory benefits, including the volume of disputes that could be generated in the Scheme and the impact on persons who are injured through the fault of another person:[262]

> *The Law Society notes that it is a long entrenched societal view that injured people believe that if they are at-fault in a motor accident they have no entitlements. Those that do claim, tend to do so without a lawyer. When disputes arise, they become self-represented litigants relying on the dispute resolution system to guide them throughout the dispute resolution process. The lack of legal representation ultimately slows down the process, and the efficiencies that result from legal representation in a tribunal setting, simply do not accrue.*
>
> *If increased numbers of at-fault people entered the Scheme, it is inevitable that disputes concerning minor injury, treatment and causation would increase. As timeframes for the cessation of benefits approach, it is foreseeable that insurer decisions regarding fault and liability would also be challenged in greater numbers.*
>
> *The Law Society is concerned that with only 12% of insurer internal reviews for minor injury decisions resulting in a decision in favour of the claimant, and extensive delays occurring in the PIC, particularly with*

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[259] Suncorp, *Submission to Review*, page 6.

[260] ALA, *Submission to Review*, page 6.

[261] Law Society of NSW, *Submission to Review*, page 6.

[262] Ibid, page 7.

> *regard to medical assessments, the Scheme's current framework is simply not equipped to handle the level of disputation that could occur.*
>
> *The Law Society's members are also well aware of the frequently deleterious psychological impact on many claimants who have been injured by the negligent actions of another who is shielded from personal liability for his or her actions by the role of the insurer and who may also be receiving benefits for his or her injuries. This impact is likely to increase if treatment benefits and/or weekly benefits continue beyond 26 weeks for those at fault.*

For our part, we query why a statutory benefits scheme should limit benefits for person's whose negligence caused an accident. It appears to us that the current scheme design reflects its origins in a common law system of fault-based liability to pay compensation, where at-fault drivers had no access to compensation. In this respect we agree with the ICA, which observed:[263]

> *Determining or differentiating entitlements in the Scheme on the basis of fault has its genesis in the common law base from which the Scheme has evolved.*

It is not unusual for insurance to cover the personal consequences of one's own negligence. A comprehensive motor vehicle insurance policy is an obvious example. Similarly, a statutory benefits scheme could legitimately and consistently with public policy support persons who are injured through their own negligence.[264] It is important to remember that the restrictions impact not only the injured person who is denied statutory benefits after 26 weeks, but also their families who depend on them and their communities in which they participate.

We are not persuaded by the argument that innocent injured persons benefit from the denial of statutory benefits to at-fault persons after 26 weeks. We accept that some innocent injured persons might prefer that the at-fault driver has more limited access to statutory benefits so as to suffer a consequence of their negligence, but we do not think that the policy setting in the Act should be founded upon that consideration. The argument on this point, on both sides of it, is about achievement of Objectives (a) and (b). Viewed this way, it seems to us that the argument weighs clearly in favour of supporting at-fault persons.

Generally we agree with the ICA's observation as follows:[265]

> *the question of entitlements provided by the Scheme to those who are considered at-fault in an accident is a matter for Government who must balance the cost to be borne by motorists, the amount of benefits that are distributed to the injured whilst ensuring that the balance is struck at a point that aligns with community values and expectations.*

However, we would make some additional observations.

First, the achievement of Objectives (a) and (b) is hindered by the limitations on statutory benefits for at-fault persons, but the limitations do not clearly advance any of its other Objectives (noting in particular that Objective (d) is limited to achieving affordability by two means only: restricting insurer profits and restricting benefits for minor injuries). Therefore, consideration of the issue should lean toward removing the limitations on statutory benefits for at-fault persons, if possible. It would be appropriate to consider doing so at this point in the life of the Scheme and, if restrictions are maintained, to keep this aspect of the Scheme under consideration.

Second, removing altogether the restrictions on at-fault benefits would benefit many injured persons in addition to just those who are wholly or mostly at fault, and the persons who depend on them. It would benefit:

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[263] ICA, *Submission to Review*, page 6.

[264] Our discussion here is limited to negligence which does not render the person liable to criminal prosecution. This is addressed in a later section of the report.

[265] ICA, *Submission to Review*, page 6.

- those who are guilty of contributory negligence even where not wholly or mostly at fault;
- a significant number of other injured persons because insurers would no longer need to make any assessment of fault for statutory benefits claims. This in itself would remove a significant source of disputes (including the dispute category that results in the most overturned insurer decisions);[266] and
- insurers, because for many claims it would potentially reduce the cost and complexity of handling them.

It would also eliminate what the ICA describes as its key concern in relation to "fraud", being single-vehicle accidents where the driver claims to be not at-fault but the insurer suspects – but cannot prove with evidence – that the driver was at fault. There would no longer be any need to consider fault.

Finally, it should be noted that if our Recommendation 37 is taken up and the period of statutory benefits for 'minor injuries' is extended to 52 weeks, then the benefit period for at-fault injured persons should also be extended. Allowing the benefit period for 'minor injury' to be longer than the at-fault benefit period could have unintended consequences in the Scheme.

For these reasons, we recommend that consideration be given to extending the period of access to statutory benefits for at-fault injured persons, at least to 52 weeks but preferably to remove the restrictions altogether.

Advice from the Scheme Actuary would be required as to the expected impact on premiums payable for CTP policies. It is possible that the impact would be offset to some extent by other advantages outlined above that may accrue from removing the fault decision in statutory benefits claims. Ultimately, it will be a matter for the legislature to decide whether some degree of restricted access to statutory benefits is needed to keep premiums affordable. To the extent that access is enhanced for at-fault benefits but not matched to not-at-fault benefits, some flow-on advantages may still occur if a higher proportion of injured persons exit the Scheme before it is necessary for the relevant insurer to consider the question of fault.

Recommendation 40

The legislature consider amending Part 3 of the Act to:

(a) extend to 52 weeks the period for which statutory benefits are available to injured persons who are wholly or mostly at fault; or

(b) remove altogether the restrictions on the entitlement to statutory benefits of injured persons who are wholly or mostly at fault.

Rationale*: The Objectives of the Scheme are to support all injured persons, and the Scheme could benefit by removing the need to determine fault in statutory benefits claims.*

3.10.3 Delay by an insurer

One circumstance in which treatment and care benefits are payable after 26 weeks to a person with only a 'minor injury' is where the "insurer delayed approval for the treatment and care expenses".[267] This addresses a situation where it would obviously be unfair to deny benefits to the claimant.

There is no equivalent that makes treatment and care benefits payable after 26 weeks to persons who are at fault. In its submission to the Review, the IRO included a case study where an at-fault claimant was impacted by a delay in claim management that the insurer accepted was "unacceptable" during the 26-week

[266] See also NSW Bar Association, *Submission to Law and Justice Review*, pages 5, 14 and 17 - 18 regarding the perceived unfairness of some practices that are used to establish fault.

[267] Clause 5.16(i) of the Guidelines.

period when statutory benefits for treatment and care were payable.[268] A delay on the part of an insurer should not have the consequence that a person is denied access to treatment and care to which they are otherwise entitled under the Act. That is so whether or not the person is at fault. There is no logical reason why it should be the case, and it is difficult to see a sound policy purpose that would justify making an at-fault claimant suffer the consequence of an insurer's delay.

In our view, the legislation should address this situation. It should do so in the same way as the 'minor injury' framework: SIRA should be able to issue Guidelines that require the payment of statutory benefits for treatment and care to at-fault persons in specified circumstances, and SIRA should issue Guidelines that have an at-fault equivalent of clause 5.16(i) which applies to 'minor injury' claims.

Recommendation 41

The legislature consider amending the Act to allow SIRA to issue Guidelines providing for the payment of statutory benefits for treatment and care after 26 weeks to injured persons who are wholly or mostly at fault, in specified circumstances.

***Rationale**: The 26-week time limit can prevent access to treatment and care benefits where there is a delay that is not the fault of the injured person.*

Recommendation 42

SIRA should issue Guidelines specifying that, in circumstances of delay caused by non-compliance by the relevant insurer with claim handling provisions, statutory benefits for treatment and care after 26 weeks are payable to injured persons who are wholly or mostly at fault to the extent that the expenses are incurred after 26 weeks due to the insurer's delay.

***Rationale**: The 26-week time limit can prevent access to treatment and care benefits where there is a delay that is not the fault of the injured person.*

[268] IRO, *Submission to Review*, page 2.

3.11 Other restrictions on statutory benefits

3.11.1 Serious driving offences

Section 3.37 of the Act states as follows:

> (1) Statutory benefits under this Part are not payable to an injured person after the person has been charged with or convicted of a serious driving offence that was related to the motor accident.
>
> (2) This section does not prevent the payment of statutory benefits if the person is acquitted of the offence charged or the proceedings are discontinued (otherwise than in circumstances of a plea of guilty to another serious driving offence that contributed to the person's injury). If the person is so acquitted or the proceedings are so discontinued—
>
> (a) statutory benefits are payable from the date the person was charged with the offence, and
>
> (b) any limitation period on proceedings for the recovery of those benefits does not commence until the person's acquittal or the discontinuance of the proceedings.
>
> (3) A serious driving offence with which an injured person is charged or convicted is considered to be related to a motor accident only if—
>
> (a) the offence relates to the driving of a motor vehicle by the injured person, and
>
> (b) the motor vehicle was involved in the motor accident that caused the person's injury.
>
> (4) A person is considered to have been charged with a serious driving offence if proceedings for a serious driving offence are pending against the person, and the person is considered to have been charged when those proceedings were commenced.
>
> (5) A serious driving offence is—
>
> (a) an offence that is a major offence under the Road Transport Act 2013 or an offence under section 115 or 116 (2) (a)–(e) of that Act, or
>
> (b) any other offence prescribed by the regulations under this Act as a serious driving offence, but does not include an offence prescribed by the regulations under this Act as excepted from this definition.
>
> (6) This section does not entitle an insurer to recover payments of statutory benefits made before the person is charged with or convicted of the relevant serious driving offence.

A question arises as to the effect of section 3.37(1) of the Act, and in particular the words "serious driving offence that was **related to** the motor accident" (emphasis added), when read with section 3.37(3). The issue is whether statutory benefits are not payable when an injured person is charged with or convicted of a serious driving offence, irrespective of whether the relevant offence *caused or contributed to* the accident. Section 3.37(3) states a necessary condition for an offence to be 'related to' a motor accident but does not, in express terms, state a sufficient condition.

The issue can be seen, but was not resolved, in the Supreme Court of New South Wales case of *QBE Insurance (Australia) Limited v Abberton* [2021] NSWSC 588. The case is a simple illustration of the issue.

In the *Abberton* case, the claimant sustained injuries in a single vehicle accident when he lost control of his vehicle and veered off the road hitting a tree. He maintained that he lost control of the vehicle because a kangaroo suddenly appeared on the road in front of him. He attempted to avoid colliding with the kangaroo. Subsequent to the accident, the claimant was issued with an infringement notice for a low range prescribed concentration of alcohol (**PCA**) offence (blood alcohol concentration (**BAC**) of 0.064).

An assessor in the DRS (which has been replaced by the PIC) considered whether:

- the motor accident was caused wholly or mostly by the fault of the claimant for the purposes of section 3.28 of the Act; and
- the insurer was entitled to refuse payment of statutory benefits under section 3.27 of the Act.

The assessor found that the claimant was charged with a serious driving offence within the meaning of section 3.37(5). That offence was the driving of a motor vehicle with a low range PCA, being a BAC reading of 0.064. The assessor found that he was required to proceed on the basis that the claimant had committed a serious driving offence within the meaning of section 3.37(5).[269]

The assessor then made the following findings:[270]

> *139. The causal elements of the definition that are underlined are not satisfied in this case. In particular, the claimant's use of his vehicle did not cause his injury. It follows that the claimant's motor vehicle was not involved in the motor accident that caused his injury and ss 3.37(3)(b) is not satisfied.*
>
> *140. In the present case, the claimant swerved to avoid a collision with a kangaroo. I have found that the motor accident is a 'no-fault motor accident' for the purpose of s 5.1.*
>
> *141. I am fortified in my conclusion concerning ss 3.37(3)(b) by consideration of s 3.38 of the Act. Subsection 3.38(2) provides that a finding of contributory negligence must be made in the following cases:*
>
> > *(a) Where the injured person has been convicted of an alcohol or other drug related offence in relation to the motor accident, unless the injured person satisfied the insurer or the Dispute Resolution Service that the alcohol or other drug involved in the commission of the offence did not contribute in any way to the accident ...*
> >
> > *(b) ...*
>
> *142. At ss 3.38(6), an alcohol or other drug related offence is defined to include PCA offences.*
>
> *143. If the insurer's submission is correct, s 3.38 could have no operation in cases of PCA offences. The claimant would not be entitled to statutory benefits and no occasion to consider contributory negligence under this provision would arise.*
>
> *144. I find that the serious driving offence was not related to the motor accident, and the claimant is not disentitled to payment of statutory benefits by reason of his commission of a serious driving offence.*

In relation to the DRS assessor's findings, the Court found that:[271]

> *the assessor erred in his construction of section 3.37(3). He considered that having made a finding that the accident was not caused by the fault of the claimant and was a no-fault accident, then section 3.37(3)(b) could not be satisfied. This was an error of law on the face of the record.*

However, it is important to note that the meaning of the words "was related to the motor accident" in section 3.37(1) was not in issue in the proceedings, and the Court was only required to consider the very limited point relating to the assessor's consideration of section 3.37(3)(b).[272] That is, the question for the Court was: as a matter of law, can the vehicle in a single vehicle accident *not* be 'involved in the motor accident', within the meaning of section 3.37(3)(b) of the Act? The Court's answer was: no. If there is a single-vehicle accident, then the only conclusion available for the purposes of section 3.37(3)(b) of the Act is that the vehicle in question was 'involved in the motor accident'.[273] In relation to section 3.37(1) of the Act, the Court said that the parties to the matter had agreed:

> *that the Court would not be asked to make any findings of the meaning of "relates to" and "related to" in s 3.37.* [The insurer's counsel] *observed that there was a difference of opinion as to whether those words*

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[269] *QBE Insurance (Australia) Limited v Abberton* [2021] NSWSC 588, per Cavanagh J at [49].

[270] Ibid, at [53].

[271] Ibid, at [74].

[272] Ibid, at [71].

[273] Ibid, at [69].

require a causal relationship or merely some type of indirect association. It had been agreed that that issue did not arise for determination in this matter.

Therefore, there remains a question as to whether a person is disentitled to statutory benefits under section 3.37 in circumstances in which the serious offence of which they are charged or convicted did not *cause or contribute to* the accident.

The ALA has submitted that, if section 3.37 denies access to statutory benefits in circumstances in which the serious offence of which an injured person was charged or convicted did not cause or contribute to the accident, then the civil law is imposing an unjust and disproportionate penalty on top of the criminal law. The usual application of principles of contributory negligence provides the appropriate civil remedy.[274]

In making its submission, the ALA cited a decision of the DRS:[275]

> *In the particular case, the claimant returned a BAC of just over 0.05. The reading was from drinking the night before rather on the day of the accident. The DRS assessor held that the claimant's low range BAC reading was in no way causative of the accident. The claimant was rear-ended whilst turning into a McDonald's carpark. Nonetheless, the DRS Assessor held that the drafting of Section 3.37 meant that the claimant was not entitled to any statutory benefits. That in turn means the claimant will be denied any compensation for past or future treatment expenses.*

We consider that the current version of section 3.37 is unclear and, as far as we are aware, its interpretation has not been resolved by the courts (including in the *Abberton* case described above). In our view, if the outcome under section 3.37 is the loss of entitlement to statutory benefits for injured persons whose injuries result from an accident where the offending conduct did not cause or contribute to the accident, this is not consistent with the Objectives of the Act.

It is clear that a person who is convicted of a serious driving offence should receive whatever punishment is required by the *Road Transport Act 2013* or any other relevant law. We do not suggest that the person should be spared the criminal or civil liability consequences of their conduct. Rather, we consider that the Act should focus on the objective of providing 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. We do not see a compelling policy objective, consistent with the Objectives of the Act, that is served by making an exception to this for persons injured through no fault of their own (notwithstanding that they may have separately committed a serious driving offence such as having a BAC above a certain level). The Act should not punish such persons by denying them treatment and care. In our view it would be consistent with the Objectives of the Act to support such persons to recover from their injuries.

We conclude that the drafting of section 3.37 should be clarified, and the provision should operate in a way that is not merely a punishment for offending conduct (in addition to the punishments specified in the *Road Transport Act 2013* or other relevant law), but as a restriction on access to the Scheme where Scheme costs would otherwise be incurred as a result of the injured person's offending conduct.

Recommendation 43

The legislature consider amending the section 3.37 of the Act to provide that statutory benefits are not payable to an injured person after the person has been charged with or convicted of a serious driving offence that caused or contributed to the motor accident.

***Rationale**: The current version of section 3.37 operates as a punishment for offending conduct, rather than as a prohibition on statutory benefits that would be payable as a result of offending conduct.*

[274] ALA, *Submission to Law and Justice Review*, page 38.

[275] Ibid, page 39.

3.11.2 Foreign residents

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.[276] Any person who resides outside Australia is only entitled to weekly benefits in respect of loss of earnings that is likely to be of a permanent nature.[277]

In the *2018 review of the Compulsory Third Party insurance scheme*, the Law and Justice Committee considered submissions by the ALA regarding the treatment of foreign tourists. The ALA submitted that:[278]

- section 3.33 of the Act be revised to provide foreign tourists with the same medical treatment rights as Australian residents; and
- section 3.21 of the Act be revised to allow foreign tourists to collect statutory benefits for lost wages (or hardship payments) without waiting for their medical condition to stabilise.

The Chair of the Injury Compensation Committee, Law Society of NSW, gave evidence to the Law and Justice Committee that it was unfair for "very badly injured" foreign tourists to "have to look after themselves when they go back home".[279]

In its recommendations, the Law and Justice Committee focused on section 3.33 relating to treatment and care provided outside Australia to persons who are not Australian citizens or permanent residents. It made a recommendation that the Government investigate the cost of amending the Act to ensure foreign tourists who are injured on New South Wales roads receive the same medical treatment benefits as Australian residents.[280]

In August 2019, the Government provided to the Law and Justice Committee its responses to the *2018 review of the Compulsory Third Party insurance scheme*. The response to the recommendation directed to foreign tourists was that the recommendation was "Supported in Principle" and the Government would request and consider advice from SIRA on analysis of the policy and costs considerations of providing foreign tourists who are injured on New South Wales roads the same medical treatment benefits as Australian residents.[281]

Our understanding is that the outcome of the advice from SIRA to the Government has not been made public. The position of foreign residents remains unchanged in the Act.

The Law and Justice Committee's recommendation and the Government's response to it are a matter of public record. Stakeholders remain concerned about the issue. For example, the ICA raised with the Review its concerns about the position of foreign residents. They submitted that injured foreign residents who are not at-fault in an accident should be eligible for some financial support for treatment and care to recover from their injuries.[282] There remains a desire on the part of certain stakeholders to understand what

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[276] Section 3.33 of the Act.

[277] Section 3.21 of the Act.

[278] Law and Justice Committee, *2018 Review of the Compulsory Third Party Insurance Scheme*, paragraph [3.16]. We note that section 3.21 of the Act applies to all persons while they reside overseas.

[279] Ibid, paragraph [3.18].

[280] Ibid, Recommendation 6.

[281] Letter from Minster for Customer Service to Legislative Council Standing Committee on Law and Justice, 7 August 2019, Attachment B: "*Government Response to Report of the Legislative Council Standing Committee on Law and Justice on 2018 Review of the Compulsory Third Party Insurance Scheme*", page 2.

[282] ICA, *Submission to Review*, page 4.

became of the Law and Justice Committee's recommendation. It seems appropriate to us that SIRA deal publicly with the resolution of the response to the recommendation of the Law and Justice Committee.

Recommendation 44

The Minister consider issuing a public statement, through SIRA, of the outcome of Recommendation 6 made by the Law and Justice Committee in its 2018 review of the Scheme.

***Rationale**: The restrictions on access to statutory benefits by foreign residents continues to be a matter of concern to stakeholders, including lawyer and insurer groups. The Scheme would benefit from a public statement of the Government's position on the issue.*

3.12 Claims related to the death of a loved one

3.12.1 Introduction

It is a tragic fact that, every year, lives are lost on the roads of New South Wales. For every one of those lives that are lost, there are families that are left behind. The trauma of losing a loved one in a motor accident is profound.

We were privileged to hear both from an individual claimant in the Scheme who suffered the loss of a loved one in a road crash, as well as the Road Trauma Support Group NSW, a newly formed group that seeks, among other things, to provide effective support to families affected by the road trauma death of a loved one. Members of the Road Trauma Support Group NSW comprise representatives of families directly impacted, the NSW Police and other grief and trauma support service providers. When we met with the Road Trauma Support Group NSW, it was represented by 5 members who all had lost a loved one in a road crash.

3.12.2 Navigating the Scheme in special circumstances

These stakeholders provided feedback on a range of matters. It was clear from the feedback that one of the key challenges faced by families who have lost a loved one is that they encounter the Scheme at a time of suffering tremendous trauma and grief which manifests in both emotional and psychological impacts. They are faced with a Scheme which, according to the Road Trauma Support Group NSW:

- is very complex and opaque;
- is very difficult for even educated professionals to understand and comprehend, often requiring specialist legal advice to assist in understanding rights, obligations and entitlements; and
- lacks simple publicly available material.[283]

The Road Trauma Support Group NSW also conveyed first-hand experience of the administrative burden in the Scheme, citing the following concerns:[284]

- *A significant amount of paperwork is required to be completed for each claimant at the worst time of their lives.*
- *Deters some family members from even making a claim - too hard, too intrusive, too controlling.*
- *For each claimant: claim form, payslips, tax statements, employment contracts. This usually requires substantial efforts from others in the affected victim's workplace or previous workplaces.*
- *Then need to provide new medical certificate every 28 days, which is excessive for long term post traumatic shock matters. This may also cause hesitation from the treating G.P. in providing ongoing certification.*
- *Payments of weekly benefits not provided unless relevant paperwork supplied, and even then sometimes payment of statutory benefits needed to be chased up with CTP insurer due to administrative oversights. 'Payments' are also regularly reduced after predetermined periods.*

We appreciate that a certain level of process, procedure and information gathering must take place to allow insurers to administer effectively the claims on the Scheme. The opportunity that, in our view, presents itself in relation to the cohort of claimants who have lost loved ones is for a formal support mechanism. In particular, we consider that such claimants should have access to a dedicated trauma specialist whose role is to assist them with the management of their trauma and their engagement with the Scheme at a time when it is difficult for them to be faced with the complexity and burden of a CTP insurance claim.

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[283] Road Trauma Support Group NSW, *Submission to Review*, page 5.

[284] Road Trauma Support Group NSW, *Submission to Review*, page 5.

We envisage that this service could be an element of CTP Assist, but with the counsellor funded by the relevant insurer (but engaged by SIRA).[285] The counsellor would be able to give individualised help to family members to understand what the Scheme provides and how it works, and to navigate the administrative burden of making a claim.

Recommendation 45

SIRA consider developing a panel of trauma support specialists with training and expertise in both trauma counselling and the Scheme. In the event of a death or catastrophic injury resulting from a motor accident, a trauma counsellor would be made available to assist family members of the deceased or injured person to take necessary steps in the period following the event to care for their psychological wellbeing as well as to assist in their early engagement with the relevant insurer.

***Rationale**: The family of deceased or catastrophically injured persons should have specialised support to avoid poor outcomes in the Scheme.*

3.12.3 'Minor injury'

There is no doubt that the family members of someone who has died or suffered a catastrophic injury will often suffer a terrible trauma. While we make no findings of a medical nature, it is reasonable to assume that the trauma will not uncommonly result in a psychological or psychiatric injury requiring treatment and care.[286] We consider that the minor injury framework is not well-suited to being applied to the family members of a deceased or catastrophically injured person if they are in that situation.

The current definition of 'minor injury' includes some psychological and psychiatric injuries. If an injured person has only 'minor injuries', their entitlement to statutory benefits for lost income, and general entitlement to statutory benefits for reasonable and necessary treatment and care, end at 26 weeks after the accident.[287] A person with only 'minor injuries' cannot be awarded damages for either economic loss or non-economic loss.

Within 3 months after lodgement of a claim for statutory benefits, the relevant insurer must tell the bereaved claimant for statutory benefits whether or not it has decided that the person's psychological or psychiatric injury is a 'minor injury'.[288] If that is the insurer's decision, the claimant must either accept that their injury is a 'minor injury', or enter a dispute resolution in which they will effectively be required to prove that their injury is not a 'minor injury' (or at least gather evidence to counter whatever evidence the insurer relies on to establish that the injury is a 'minor injury'). For the purposes of the insurer's decision at 3 months, the insurer can require the claimant to undergo a medical examination by a health practitioner nominated by the insurer.[289]

We received feedback from claimants that, for persons in this situation, undergoing an assessment by an insurer to determine whether the impact of the death of a loved one is a 'minor injury' is itself traumatic. We doubt whether there is a countervailing benefit to any other stakeholder in the Scheme.

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[285] We note also that Deloitte recommend a review of whether a complex claims case team with expertise in supporting matters such as weekly benefit calculations, would further enhance the capability of CTP Assist, in order to help injured persons better navigate the NSW CTP Scheme and understand their benefit entitlements. The trauma counsellor would be able to perform a role which would complement the functions of any complex claims case team.

[286] Statutory benefits claims and damages claims alike are affected by the limitations on pure mental harm set out in Part 3 of the *Civil Liability Act 2002*: section 3.39 of the Act.

[287] Section 3.28 of the Act.

[288] Section 6.19(2).

[289] Section 6.27(1)(a) of the Act.

In its submission to this Review, the ALA proposes that:[290]

> *In relation to death claims, families should not be put through the wringer of the minor injury test for psychiatric impairment. Deem that for any parent who loses a child, a child who loses a parent or person who loses a spouse or sibling, there will be more than a minor injury without putting them to proof. This will not open any flood gates as it will still be necessary to establish loss in order to recover both statutory benefits and damages. If a person within this category loses a close relative and makes an adequate recovery with no ongoing psychiatric impairment, then there will be no need for treatment expenses, there will be no wage loss, and they will not have injuries over 10% WPI. The concession as to minor injury costs the insurer little, but extends some degree of dignity to the person concerned in not attaching a "minor injury" label to their situation*.

We query whether the trauma of the death or catastrophic injury of a loved one can ever be expected to resolve by 6 months. We recognise that this trauma is not to be confused with the psychological or psychiatric injury that may result. However, in our view persons who have developed such injuries in these circumstances should be supported. There is probably little benefit to be had from requiring insurers to undertake 'minor injury' assessments of claimants in this category and communicate with them about that assessment, and there is potential detriment to the injured person. In trying to achieve the right balance between the Objectives of the Act, we must remain compassionate for those who are severely impacted by motor accidents on the roads of New South Wales. The 'minor injury' framework exists to remove benefits that the law would otherwise provide, to limit the opportunities and incentives for fraud in the Scheme and to reduce the costs to the Scheme of compensation payments. We agree with submissions to the effect that the family members of someone who has died or suffered a catastrophic injury in a road crash ought not to be within this framework. We recommend removing from the meaning of 'minor injury' a psychological or psychiatric injury resulting from the death or catastrophic injury of a family member.

Recommendation 46

The legislature consider amending section 1.6 of the Act (Meaning of 'minor injury') to provide that a psychological or psychiatric injury resulting from the death or catastrophic injury of a family member is not a 'minor injury' for the purposes of the Act.

***Rationale**: The Scheme should minimise unnecessary stress on grieving family members.*

3.12.4 Additional issues

Submissions by the Road Trauma Support Group NSW raised additional issues. Certain of these, although they affect the Scheme, relate to matters that are governed by legislation other than the Act, Regulations and Guidelines. Others do concern the design or implementation of the Act, Regulations and Guidelines and we comment on two of these below.

CTP Assist

The Road Trauma Support Group NSW advocates for the introduction of a 'Consumer Guide to CTP' for the benefit of injured persons. The same idea was proposed by another claimant with whom we spoke, who was severely injured in a motor accident. This claimant provided copies of published guides that relate other services, including hospital, coroner and pregnancy and childbirth, by way of examples of consumer guides; and even created and provided to us a template and draft content for a guide to CTP.

We encourage SIRA to consider producing a 'Consumer Guide to CTP' that would be given or made available to all claimants in the Scheme, as part of the CTP Assist service.

[290] ALA, *Submission to Review*, page 5.

Funeral expenses

Section 3.4 of the Act creates an entitlement to statutory benefits for funeral expenses if the death of a person results from a motor accident. The entitlement is to "reasonable funeral expenses", which "are to include the reasonable cost of transporting the body of the deceased" to either an appropriate place for preparation for burial or cremation, or the deceased person's usual place of residence.

There is arguable a lack of clarity about what exactly is covered by "reasonable funeral expenses". The independent claim file reviews recommended by Deloitte could include consideration of how insurers apply the provisions of section 3.4. Depending on the outcome of those reviews, SIRA may want to consider communicating with insurers about its expectations for how section 3.4 should be applied.

3.13 CTP Care

3.13.1 Introduction

The Lifetime Care and Support Authority of New South Wales (**LTSCA**) is constituted under the *Motor Accidents (Lifetime Care and Support) Act 2006* (**LTCS Act**).

LTCSA administers the Lifetime Care and Support Scheme in accordance with the LTCS Act. The LTCS Scheme is a no-fault scheme that provides lifetime treatment, rehabilitation, and care to people who suffer certain severe injuries in motor vehicle accidents in New South Wales. People entitled to treatment and care under the LTCS Scheme are not entitled to statutory benefits for treatment and care under the Act.[291]

LTCSA also has a role under the Scheme created by the Act (that is, for injured persons who are not in the LTCS Scheme). Under section 3.2(5) of the Act, in the case of the payment of statutory benefits of treatment and care provided more than 5 years after the motor accident concerned, the 'relevant insurer' is LTCSA. This has the effect that the person liable to pay the statutory benefits is LTCSA.[292] When this occurs, the injured person's claim comes under the management of LTCSA. LTCSA provides this service to claimants under the brand, 'CTP Care'.

LTCSA's liability to pay treatment and care benefits after the first 5 years of a claim is funded by levies on CTP policies,[293] paid into the Motor Accident Injuries Treatment and Care Benefits Fund (**MAITC Benefits Fund**).[294]

Under section 3.45(2) of the Act, LTCSA may become the 'relevant insurer' in relation to treatment and care for the purposes of Part 3 of the Act, in place of the insurer, even before 5 years have passed if LTCSA and the insurer agree for LTCSA to assume that responsibility (**CTP Care Agreement**). While a CTP Care Agreement is in effect, the insurer is liable under section 3.45(3) of the Act to pay to LTCSA the amount required to fund LTCSA's liability as the 'relevant insurer'.

During consultation meetings, LTCSA told us that they currently had 6 injured persons in CTP Care as a result of CTP Care Agreements. There are no other injured persons in CTP Care because the Scheme is less than 5 years old. After 5 years have passed since the start of the Scheme (i.e. after 1 December 2022), we assume that there will be a relatively rapid increase in the number of claims under the management of CTP Care.

3.13.2 Regulation of the LTCSA

Section 3.45(1) of the Act provides as follows:

> The description of the Lifetime Care and Support Authority as the relevant insurer for the purposes of this Act does not make that Authority an insurer when it exercises functions under this Act, but provisions of this Act relating to insurers extend (subject to the regulations) to that Authority in connection with the exercise of those functions.

Thus, the exercise of functions by LTCSA as the 'relevant insurer' is subject to the same provisions of the Act that govern the exercise by insurers of those functions.

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[291] Section 3.32 of the Act.

[292] Section 3.2(1).

[293] Section 10.16(1)(b) of the Act.

[294] Section 10.14 of the Act.

Part 9 of the Guidelines contains provisions governing the transfer under section 3.45(2) of the Act of responsibility to pay statutory benefits from the insurer to LTCSA. It also contains provisions governing the handling of statutory benefits claims by LTCSA.

In its submission to the Law and Justice Review, SIRA stated the following:[295]

> *SIRA implements strong oversight and governance of CTP Care. In consultation with LTCSA, CTP insurers and peak legal bodies, SIRA has finalised the CTP Care Guidelines which will be published in the Motor Accident Guidelines in October 2020. The Guidelines set out the requirements for the transition of the management of treatment and care benefits payments for requirements, complaints handling, treatment and care, customer experience and data provision. SIRA will carefully monitor and report on LTCSA claims management against these requirements.*

After this Review had commenced, SIRA wrote to us asking that we review the arrangements under the Act for regulatory oversight of LTCSA, stating the following:[296]

> *SIRA has limited ability to regulate LTCSA in the exercise of its functions as the relevant insurer for the payment of statutory benefits for treatment and care under sections 3.2 and 3.45 of the 2017 Act. Currently, SIRA can escalate any concerns about LTCSA's performance to the Minister but is unable to impose any penalties or prevent LTCSA from exercising its functions inconsistent with the CTP legislation and its objectives, as it can with a regular licensed insurer.*

We have considered carefully this important topic. We sought feedback from, and engaged with, LTCSA. Services (including staff and facilities) are provided to LTCSA by Insurance and Care NSW (**icare**).[297] The Group Executive Lifetime Schemes of icare made a submission in response on behalf of LTCSA.[298]

LTCSA emphasises that:

- SIRA's current regulatory powers appear appropriate given experience to date and level of risk, and there does not need to be any modification to the scope of SIRA's regulation at this time;
- LTCSA has a different role in the Scheme compared with the insurers and a different approach to regulation of LTCSA may be warranted;
- at this stage, no particular benefits of additional regulation had been identified;
- it would nevertheless support further review of regulation after there is more experience in CTP Care; and
- it would like the opportunity to make further submissions if a concrete proposal is made for the benefits to derive from additional regulation of CTP Care.

We generally agree with icare's submissions on behalf of LTCSA having regard to the current stage of the Scheme's development, and we do not make any recommendation relating to SIRA's regulatory oversight of LTCSA or the conduct of CTP Care.

We recommend that, in future reviews of the Act, Regulations and Guidelines – including reviews by the Law and Justice Committee – further consideration should be given to SIRA's request for additional regulatory oversight. Further, we consider that the provisions governing regulatory oversight of CTP Care would be better reviewed in light of specific issues that may be identified, having regard to the exercise of functions under the Act by LTCSA in the implementation of its role in the Scheme.

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[295] SIRA, *Submission to Law and Justice Review*, page 32.

[296] SIRA, Letter to Clayton Utz and Deloitte dated 9 June 2021.

[297] Section 10(1)(b) of the *State Insurance and Care Governance Act 2015*.

[298] LTCSA, *Supplementary Submission to Review*.

For completeness, we add that we do not consider it necessary for the Act to provide for regulatory oversight of icare in respect of CTP Care. As a body corporate, icare has no role in the Scheme. It is merely a provider of services and personnel to LTCSA to enable LTCSA to carry out its role in the Scheme. LTCSA is the appropriate locus of SIRA's regulatory oversight.

3.13.3 Counterparty risk to the MAITC Benefits Fund

In icare's submission to the Review on behalf of LTCSA, it noted that when LTCSA enters into a CTP Care Agreement for an injured person to transfer early to CTP Care (i.e. before the expiry of 5 years), the liability to pay statutory benefits transfers to the LTCSA, but pursuant to the terms of the CTP Care Agreement this liability is funded by the insurer on a cost-recovery basis.[299] This method for the insurer to fund LTCSA's liabilities was adopted to prevent any funding shortfalls which may occur if the costing was done on the basis of an upfront lump sum.[300]

The effect of this is that LTCSA may rely on ongoing payments into the MAITC Benefits Fund from a licensed insurer in order to be able to meet LTCSA's liability to pay statutory benefits to an injured person. However, in the event of a licensed insurer experiencing an insolvency, the MAITC Benefits Fund may not hold enough funds to cover the treatment and care needs of the relevant injured person (since it may not have received an upfront lump sum sufficient to meet all of the person's future treatment and care needs).

Division 9.4 of the Act sets out provisions that apply in the event that a licensed insurer becomes an 'insolvent insurer'.[301] Its provisions have the effect, among other things, of appointing the Nominal Defendant (that is, SIRA[302]) as the agent of persons who are insured under CTP policies issued by the insolvent insurer, for the purpose of discharging liabilities of those persons that should otherwise be indemnified under the CTP policies issued by the insurer.

A person who is insured under a CTP policy may be liable to pay damages to others who are injured as a result of their acts or omissions. Under the CTP policy, the insurer indemnifies the insured person against this liability[303] – that is why the insurer will pay the damages. This is the responsibility that SIRA will assume under Division 9.4 of the Act – SIRA will become the agent of the driver who is liable to pay damages, and may pay the damages on their behalf. In this way, the injured person to whom the damages are payable does not bear the consequences of the insurer's insolvency. If SIRA pays damages on behalf of an at-fault driver in this way, the payment is funded out of the Nominal Defendant's Fund established under section 2.38 of the Act.[304]

It is notable that SIRA, as the Nominal Defendant, does not assume any role under Division 9.4 of the Act to pay liabilities *of the insolvent insurer*, only liabilities of at-fault drivers. As a result, LTCSA is concerned in about an insolvent insurer's liabilities under CTP Care Agreements,[305] and proposed that the Nominal

[299] The insurer's liability to pay arises under section 3.35(3) of the Act, but the CTP Care Agreement governs the manner in which the insurer discharges the liability.

[300] LTCSA, *Submission to Review*, page 5.

[301] 'Insolvent insurer' is a term that is defined in section 9.33(1) of the Act.

[302] Sections 1.4(1) and 2.27 of the Act.

[303] Section 2.3 of the Act.

[304] Section 9.39(1) of the Act.

[305] LTCSA, *Submission to Review*, page 5.

Defendant's Fund be obliged to cover any outstanding payments under a CTP Care Agreement entered into by a licensed insurer who later experiences insolvency.[306]

In our view, having regard to the provisions of sections 9.27 and 9.39(1)(a) of the Act, LTCSA's concern is well founded. There is a risk that, in the event of an insurer insolvency, the MAITC Benefits Fund may not have sufficient funds to cover all of the future treatment and care of a person in CTP Care and, at the same time, there may not be an ability to apply money in the Nominal Defendant's Fund to pay for that treatment and care.

We recommend that changes be made to require SIRA, as the Nominal Defendant, to discharge the obligations of an insolvent insurer under a CTP Care Agreement out of the Nominal Defendant's Fund.

It appears to us that there is the potential for an additional gap in Division 9.4 of the Act. The person liable to pay statutory benefits under Part 3 of the Act is the relevant insurer.[307] Our concern is that, when the Nominal Defendant becomes the agent of an at-fault driver in order to discharge that person's liabilities covered by a CTP policy, it could be said that it is not obliged to discharge the *insurer's* liability to pay statutory benefits to injured persons. This is because section 3.2 in its terms does not state that the liability to pay statutory benefits is a liability of the at-fault driver which the insurer then indemnifies under a CTP policy. In its terms, it places the liability directly on the insurer. Division 9.4 of the Act makes no provision for who will pay statutory benefits to injured persons if the relevant insurer does not pay because of insolvency. We recommend that this be addressed.

Recommendation 47

The legislature consider amending Division 9.4 of the Act to provide that, in addition to existing provisions requiring the Nominal Defendant to discharge the obligations of a person insured under a third-party policy issued by an insolvent insurer, the Nominal Defendant is to discharge the obligations of the insolvent insurer:

(a) under Part 3 of the Act; and

(b) under any agreement entered into with the Lifetime Care and Support Authority under section 3.45(2) of the Act.

***Rationale**: The insolvency provisions of the Act need refinement to deal expressly with the liabilities of insurers to injured persons, in addition to liabilities to pay damages.*

3.13.4 Additional matters relating to CTP Care

LTSCA made submissions proposing consideration be given to amending the Act, Regulations and Guidelines in certain other respects. These included:[308]

- the extent to which the Act recognises and accommodates the long-term care aspect of the Scheme, including whether the Objectives should be "broadened to include an objective to minimise loss and maintain health and function where early recovery cannot occur";
- the development "guidelines and procedures to manage chronicity", including with the benefit of research and clinical guidance on which LTCSA proposes to collaborate with SIRA;

[306] Ibid, page 5.

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

[308] LTCSA, *Submission to Review*.

- the management of treatment and care in the period approaching 5 years after the motor accident concerned, when there may be a risk that the insurer's management of the claim becomes less proactive;
- a range of specific issues that could affect the long-term care aspect of the Scheme, including in relation to treatment and care for 'minor injuries', reassessment of previous determinations of medical maters, third-party recoveries against the MAITC Benefits Fund, the timeframe for determining treatment and care requests in claims that have become inactive, and access to police information about the location of a motor accident.

We agree with LTCSA that each of these matters warrants consideration. However, for reasons similar to those that lead to our conclusion about the nature and extent of SIRA's ability to regulate LTCSA, our view is that they are matters that should be the subject of consideration in a future review of the Act, Regulations and Guidelines. The next such review will have the benefit of LTCSA's experience implementing CTP Care for those who transition to its service after 5 years from the motor accident. That experience may be important to inform both whether a particular concern remains after implementation and the precise nature of any amendment to the Act, Regulations or Guidelines that may be required.

3.14 SIRA's power to impose a civil penalty

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,[309] 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 asked us 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.[310] Although section 9.10 gives SIRA the power to issue a letter of censure or impose a civil penalty, before so imposing a civil penalty SIRA must proceed through several steps including taking advice from a 'special committee' of the Chairperson of SIRA's Board, a nominee of the ICA and another person jointly nominated by SIRA and the ICA. The special committee must give the insurer an opportunity to make written submissions to the committee on the matter (but is not required to conduct a hearing).

A number of stakeholders held the view that it was peculiar that one of the members of the committee tasked with advising SIRA about imposing civil penalties on insurers was a member of the ICA. Others considered it out of the ordinary that the regulator is given the direct power to impose a civil penalty, in comparison with regulators in the federal jurisdiction, who must apply to a court for a civil penalty to be imposed by the court. In our consultation, the ICA supported the 'special committee' process in section 9.10 because it serves a procedural fairness function, but considered that there could be scope to simplify the process for convening the committee to facilitate the swift exercise of SIRA's regulatory function.

In the federal jurisdiction, civil penalties are enforced by a court on the application of a regulator. This is underpinned by the *Regulatory Powers Act 2014* (Cth), which creates a framework for the use of civil penalties to enforce civil penalty provisions. If a Commonwealth Act uses the words 'civil penalty' it will be a civil penalty provision and an authorised person will need to apply to a relevant court for an order that the person pay the Commonwealth a pecuniary penalty. There are constitutional considerations in the federal jurisdiction that do not necessarily apply in State jurisdictions.

The position is nevertheless similar in certain New South Wales legislation.[311] However, there are other instances of New South Wales legislation that allow a regulatory body to impose a civil penalty without commencing proceedings in a court.[312] The Act is one of those pieces of legislation.

What is apparent to us from a consideration of section 9.10 of the Act is that it has three aspects that could be improved to achieve a more effective and efficient enforcement mechanism.

First, section 9.10 operates to permit SIRA to impose a civil penalty or issue a letter of censure "instead of suspending the insurer's licence".[313] In our view, this potentially sets an unnecessarily high threshold for SIRA to overcome in order to engage section 9.10. We can envisage that there will be a number of

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[309] 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.

[310] SIRA, Letter to Clayton Utz and Deloitte dated 9 June 2021.

[311] See, for example, the *Cemeteries and Crematoria Act 2013* (NSW) part 6 div 2; Co-Operatives National Law (appendix to *Co-operatives (Adoption of National Law) Act 2012* (NSW) s 554; *Entertainment Industry Act 2013* (NSW) s 43; *Fair Trading Act 1987* (NSW) s 54D; *Industrial Relations (Child Employment) Act 2006* (NSW) s 15; *Industrial Relations Act 1996* (NSW) s 357; and *Work Health and Safety Act 2011* (NSW) s 255.

[312] See, for example, the *Home Building Act 1989* (NSW) s 105M, sch 4 cl 95; *Workers Compensation Act 1987* (NSW) s 183A; *Civil and Administrative Tribunal Act 2013* (NSW) s 77; *Community Land Management Act 2021* (NSW) s 207; *Harness Racing Act 2009* (NSW) s 30; *Strata Schemes Management Act 2015* (NSW) s 147; *Thoroughbred Racing Act 1996* (NSW) s 29C; *Water Management Act 2000* (NSW) s 78.

[313] Section 9.10(1) of the Act.

instances in which an insurer may have contravened its licence, or the Act, the Regulations or the Insurance Industry Deed, where the sanction should not be suspension of the insurer's licence but a penalty or letter of censure under section 9.10 is warranted. If section 9.10 only operates in circumstances where it is open to SIRA to suspend an insurer's licence, then in our view SIRA's power is too limited. If this is not the effect of the words "instead of suspending the insurer's licence", then they are unnecessary and should be removed. We recommend an amendment to remove the limitation on the section, so that it does not only apply "instead of suspending the insurer's licence".

Second, section 9.10 requires the special committee to give the licensed insurer concerned an opportunity to make written submissions with respect to the alleged contravention.[314] We query whether that requirement creates an inefficient duplication in the enforcement process, with the insurer making submissions both to SIRA before the matter is referred to the special committee, and then to the special committee itself. Alternatively, an inefficiency would arise if the insurer were not given the opportunity to make submissions to SIRA and, in making submissions to the special committee, it became apparent that a submission before referral to the special committee would have been the end of the matter. In our view, and assuming that referral to the special committee remains part of the section 9.10 process (and we discuss below why it should not), a more efficient process would be to give the licensed insurer an opportunity to make written submissions to SIRA with respect to the alleged contravention. SIRA can then consider those submissions before making the referral to the special committee which, if made, would simply be accompanied by a copy of the insurer's submissions.

Finally, the special committee is to comprise the Chairperson of the Board of SIRA, a nominee of the ICA and another member nominated jointly by SIRA and the ICA.[315] The ICA is the representative body for the general insurance industry of Australia. As we understand it, the ICA performs a role which involves representing the interests of insurers. We query whether a nominee of the ICA could sit on the special committee without being in a position of intractable conflict or subject to a perception of bias. We assume that it may be argued that the ICA nominee is intended to sit on the special committee for the precise purpose of providing a partial perspective in the interests of the insurer. We consider that this would not be an appropriate justification for the ICA nominee to be a member of the special committee. SIRA is independent and performing a regulatory function. We consider that it should be recognised as such and does not require advice from a special committee that includes a member representing the insurance industry. The insurer itself will have the right to make submissions in its own interest. Another possibility is that the ICA nominee is part of the special committee to facilitate advice to SIRA which has the benefit of industry knowledge, experience and insight. Again, we do not accept that this could be necessary. SIRA has the knowledge, experience and expertise to be able to perform its regulatory function without assistance from the insurers that it regulates.

The current composition of the special committee is not appropriate for a role in a process to consider imposing a civil penalty on an insurer. Furthermore, if that criticism is warranted and it is not appropriate that a representative of the ICA should be on the special committee, then we query the need for the special committee at all. In our view, SIRA should be allow to proceed independently and efficiently in the process contemplated by section 9.10. We recommend removing the role of the special committee entirely.

[314] Section 9.10(3)(b) of the Act.

[315] Section 9.10(3)(a) of the Act.

Recommendation 48

The legislature consider amending section 9.10 of the Act to:

(a) remove the limitation on the section, so that it does not only apply "instead of suspending the insurer's licence";

(b) provide that the licensed insurer concerned must be given an opportunity to make written submissions to SIRA with respect to the alleged contravention; and

(c) remove the requirement on SIRA to refer the matter to a special committee for advice.

Rationale*: SIRA should have an efficient and effective power to impose penalties and censure behaviour of insurers that warrants that action. The process governing SIRA's power to impose a civil penalty should align with other, similar, legislation.*

3.15 Road safety

The Act does not include an objective directed to road safety. However, the Scheme is established to support those impacted by death and injury as a consequence of motor accidents on roads in New South Wales which, unfortunately, are not completely safe. The question then arises as to the role of the Scheme in supporting better road safety which, in turn, will minimise the burden on the Scheme and the need for injured persons to rely on the support that it provides.

The benefits to all stakeholders in the Scheme of safer roads are, we submit, obvious. Increased road safety would mean fewer accidents, fewer injuries and deaths (and a consequent reduction in pain, suffering and trauma), reduced burden on the Scheme and increased premium affordability.

Furthermore, the Scheme is designed not to fully compensate injured persons for their loss, including where the law that would otherwise apply *would* entitle an injured person to be compensated fully.[316] Arguably, this aspect of the Scheme makes it appropriate that the Scheme should also be designed, where possible, to assist in the prevention and minimisation of injuries from motor accidents so that as few people as possible have to claim under the Scheme, and motorists participate simply as CTP policyholders.

The Act already contemplates that SIRA has a function to provide funding for measures for preventing or minimising injuries from motor accidents, and safety education.[317] In our view the Act should go further.

There were mixed views from stakeholders to our suggestion that there be added to the Act an objective directed to promotion of road safety. It was clearly supported by a number of stakeholders. Others were concerned that as SIRA has little to do with road safety, and the Scheme is privately underwritten, such an objective may add more complexity without addressing existing issues within the Scheme. A few stakeholders considered that road safety has not traditionally been within SIRA's ambit, and there was a concern that steps taken to achieve such an objective may divert resources from the Scheme's core purpose of ensuring support for injured persons. Finally, some questioned whether doing so could realistically have any impact on the prevention of accidents.

In our view, the Scheme may not have primary responsibility for road safety in New South Wales, but certainly has a role to play in supporting the broad objective and the collective efforts of the Police, the Centre for Road Safety and all agencies, departments and other arms of the Government who collaborate and contribute to road safety. The role of insurance and insurers in promoting risk management is clear across all types of risks, and the use of motor vehicles is no exception.

The insurance industry has always had a role to play in helping their insureds to manage the risks for which they are insured. Managing risk is in both the insurer and the insured's interests. For example, a property insurer may require fire protection systems in a building or an insurer of cyber risks may require minimum standards of information technology security. The underwriting of risk by insurers can both encourage and reward the insured's risk management. The motor vehicle insurance industry is increasingly looking at innovations such as telematics that capture driver behaviour which, if shown by the data collected to exhibit safe driving characteristics, can both assist the insurer's underwriting and justify the insured receiving favourable pricing. It seems to us that CTP insurance can also play its role. A submission to the Review from the Australasian College of Road Safety (**ACRS**) drew attention to a 'Young Drivers Telematics Trial' conducted in 2018-2019 by SIRA in partnership with the Centre for Road Safety, on the potential for telematics to improve the safety of young drivers:[318]

> *The significance of the project is such that both the commencement of the trial, and the release of results, were accompanied by Ministerial media releases.*

[316] See, for example, section 1.3(3)(b) of the Act.

[317] Section 10.1(1)(j) of the Act.

[318] ACRS, *Submission to Review*, pages 6 - 7.

Announcing the trial, NSW Finance and Services Minister Dominello said, "we want the NSW CTP, to be cutting edge and this technology has the potential to reduce Green Slips for young drivers. Most importantly, this technology has the potential to save lives."

Heralding results of the project in September 2019, NSW Roads Minster Constance said, "this trial has been a game changer, proving Telematics has the potential to not only make young drivers safer and better, but also save lives."

The full report into the project, also released some two years ago, alluded to "future rollouts". We await advice from SIRA and/or Government on the fate of Young Drivers Telematics.

(Citations omitted.)

We assume that SIRA continues to provide funding directed to road safety and that insurers may already be taking steps to encourage safer driving. On the other hand, road safety in New South Wales can still be improved, and providing funding for road safety initiatives is not the only way to achieve this. Therefore we recommend the introduction of an objective to promote the prevention of motor accidents and safety in use of motor vehicles. The significance of an express objective under the objects of the Act[319] is that it provides the backdrop against which the legislation is applied and interpreted. Furthermore, in the exercise of a discretion conferred by the Act or the Regulations the person exercising the discretion must do so in a way that would best promote the objects of the Act.[320] Lastly, under the Innovation Support mechanism in clause 8 of the TEPL Guidelines, insurers may be rewarded financially in respect of a successful innovation that promotes the Objectives of the Act.[321] A road safety Objective would bring innovations in this respect clearly within the bounds of the Innovation Support framework.

Recommendation 49

The legislature consider amending the Act to insert a new object of the Act under section 1.3(2) in Division 1.1 as follows:

(i) to promote the prevention of motor accidents, and safety in the use of motor vehicles.

***Rationale**: All stakeholders in the Scheme, and the Scheme itself, will benefit from safer roads and a reduction in the occurrence and severity of injuries from motor accidents.*

[319] Section 1.3 of the Act.

[320] Section 1.3(5) of the Act.

[321] Clause 2(4A) of Part 2 of Schedule 4 to the Act.

3.16 Law and Justice Review

The Law and Justice Committee tabled its '2020 Review of the Compulsory Third Party insurance scheme' report on 30 July 2021 (**Law and Justice Report**). The Law and Justice Committee made one recommendation in its report, which was directed to this Review and reads as follows:[322]

> *That the current statutory review of the Motor Accident Injuries Act 2017 closely consider the following issues for reforms to the scheme:*
>
> - *whether the no fault statutory benefit period should be expanded to a minimum of 52 weeks*
> - *how the minor injury definition can be amended to ensure it does not exclude those with genuine minor injuries, including in relation to psychological claims*
> - *whether the 20 month cooling off period should be reduced or abolished, to facilitate the faster resolution of some claims*
> - *the provision of legal support to claimants in the scheme, particularly in relation to disputes, including the internal review process*
> - *how to improve transparency and accountability in relation to insurer profits and premium setting.*

We have considered this recommendation and the specific issues it raises. Our recommendations in respect of these issues are contained in other sections of this report. We summarise them below.

3.16.1 No fault statutory benefit period

We considered the current 'no fault statutory benefits period' – being 26 weeks, the period of time for which statutory benefits are payable irrespective of fault – and concluded that the period should be extended.

In our view, the period should be extended such that there is no longer any need to consider the question of fault in a statutory benefits claim. At a minimum, the period should be extended to 52 weeks in line with our recommendation to extend the period of weekly benefits for minor injuries to 52 weeks (Recommendation 37). This is necessary to ensure that the issues of minor injury and fault continue to be considered at the same time in a statutory benefits claim.

Specifically, Recommendation 40 is that the legislature consider amending Part 3 of the Act to:

(a) extend to 52 weeks the period for which statutory benefits are available to injured persons who are wholly or mostly at fault; or

(b) remove altogether the restrictions on the entitlement to statutory benefits of injured persons who are wholly or mostly at fault.

3.16.2 Minor injury definition

The language of the Law and Justice Committee's recommendation on 'minor injury' appears, on its face, to be addressed to a concern that some genuinely minor injuries are not captured by the 'minor injury' definition.

However, we understand the concern to be whether the definition needs refinement to avoid inappropriately including injuries that are *not* genuinely minor, in an ordinary sense. Stakeholder feedback on the 'minor injury' definition has generally been in either of two categories, being: (i) the 'minor injury' definition is appropriate, or (ii) the 'minor injury' definition casts too wide a net and captures some injuries that should not be regarded as 'minor' for the purposes of the Scheme.

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[322] Law and Justice Report, page 20.

In any event, our Recommendations 34 to 39 relate to the 'minor injury' framework. At a general level, those recommendations are to the effect that:

- 'adjustment disorder' should not be within the definition of 'minor injury' because the diagnosis is not an indication that the injured person's psychiatric injury will resolve by 26 weeks after the accident;
- the Guidelines relating to the use of diagnostic imaging for the purpose of making the 'minor injury' decision should be amended;
- injured persons with a degree of permanent impairment greater than 10% should be entitled to claim damages irrespective of the 'minor injury' classification of their injuries;
- the current 26-period of statutory benefits for persons with 'minor injuries' should be extended to 52 weeks;
- SIRA should undertake a consultation to identify an alternative term for 'minor injury', with a view to proposing that the term be changed; and
- a change of the insurer's position in relation to classifying a person's injuries as 'minor injuries' should be confirmed independently if the change occurs more than 18 months after the motor accident.

Aside from the issue of adjustment disorder – a diagnosis which clearly should not be within the definition of 'minor injury' – the Review received some technical submissions on the content of the definition. We were not in a position to undertake the work required to consider submissions of that nature. As alluded to by SIRA in the hearings for the Law and Justice Review, this requires specific consultation with medical and allied health professionals.[323] SIRA indicated that this is what is happening "throughout the life of the Scheme"[324] and we assume that SIRA will continue this work, including by giving specific consideration to the technical issues raised in submissions to our Review.

3.16.3 20 month cooling off period

Recommendation 17 relates to the current requirement for an injured person with a degree of permanent impairment 10% or less to wait 20 months before lodging a claim for damages. All stakeholders agreed that this aspect of the Scheme should be removed. We also agree. We have recommended that SIRA undertake a review of the lodgement of damages claims under the Act, and that the review should proceed on the basis that the 20 month wait and the accompanying 24-month prohibition on settling claims be removed. A review is needed to ensure that any provisions that replace the 20-month wait are appropriate both to balance, and to help achieve, the Objectives of the Act.

3.16.4 Provision of legal support

The framework for provision of legal support in the Scheme is complex and, in our view, overly restrictive. SIRA recently released a report by Taylor Fry on the model for access by claimants to legal services. This will address some, but not all, of the issues that need to be addressed. We envisage that SIRA will need to undertake a further round of consultation on specific, proposed solutions to the issues. In this report, we have set out some of the principles that should guide consideration of solutions, and some of the issues in addition to the model of access that need to be addressed. This aspect of the Scheme is the subject of our discussion on 'Restrictions of access to paid legal services' and Recommendation 30.

[323] Law and Justice Review, *Hearing Transcript*, 26 May 2021, page 42 (Ms Donnelly).

[324] Id.

3.16.5 Transparency and accountability

Recommendation 33 is for SIRA to develop and issue a public statement of its policy for the publication of information about assessment of insurer profit under the TEPL Guidelines and section 2.25 of the Act (including information about insurer profit and SIRA's decision-making), as well as information about the application of the Innovation Support provision in the TEPL Guidelines. Adopting this recommendation would see SIRA set expectations in relation to the disclosure of insurer profits and the reasons for its position.

3.17 List of References

3.17.1 Legislation and legislative instruments

Civil Liability Act 2002 (NSW)

Health Records and Information Privacy Act 2002 (NSW)

Motor Accidents Compensation Act 1999 (NSW)

Motor Accident Guidelines (version 7) 2021

Motor Accident Guidelines: Determination of insurance premiums for taxis and hire vehicles 2018

Motor Accident Guidelines: Transitional Excess Profits and Transitional Excess Losses 2019

Motor Accident Injuries Act 2017 (NSW)

Motor Accidents and Workers Compensation Legislation Amendment Bill 2021 (NSW)

Motor Accident Injuries Regulation 2017 (NSW)

Motor Accidents (Lifetime Care and Support) Act 2006 (NSW)

Personal Injury Commission Act 2020 (NSW)

Privacy and Personal Information Protection Act 1998 (NSW)

Road Transport Act 2013 (NSW)

State Insurance and Care Governance Act 2015 (NSW)

3.17.2 Cases

QBE Insurance (Australia) Limited v Abberton [2021] NSWSC 588

3.17.3 Reports and similar documents

ASIC, *Public comment on ASIC's regulatory activities*

Australian Institute of Health Innovation, *Review of the first 1000 claims in the new 2017 CTP Scheme: Final Report*, July 2020

Clayton Utz and Deloitte, *Statutory Review of the Motor Accident Injuries Act 2017: Discussion Paper*, 5 July 2021

CTP Reference Panel, *CTP reform consultation observations*, September 2016

Fronsko, A., *Report of the Independent Review of the Operation of SIRA's Legal Advisory Service Pilot*, May 2019

General Purpose Standing Committee No. 1, *Personal Injury Compensation Legislation*, December 2005

Ipp, D., P Cane, D Sheldon and I Macintosh, *Review of the Law of Negligence: Final Report*, September 2002

Letter from Minster for Customer Service to Legislative Council Standing Committee on Law and Justice, 7 August 2019, Attachment B: "*Government Response to Report of the Legislative Council Standing Committee on Law and Justice on 2018 Review of the Compulsory Third Party Insurance Scheme*"

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

New South Wales Government, *Response to the Legislative Council General Purpose Standing Committee No. 1 Inquiry Report into Personal Injury Compensation Legislation*, 8 June 2006

Law and Justice Committee, *2018 Review of the Compulsory Third Party insurance scheme*, Report 68, February 2019

Law and Justice Committee, *2020 Review of the Compulsory Third Party insurance scheme*, Report 77, July 2021

Law and Justice Review, *Hearing Transcript*, 25 May 2021

Law and Justice Review, *Hearing Transcript*, 26 May 2021

SIRA, *2020 Review of Minor Injury Definition in the NSW CTP Scheme*, Undated

SIRA, *CTP for taxis and hire vehicles in the point to point industry: Consultation Paper*, February 2021

SIRA, *CTP Premium & Market Supervision: Review of the Risk Equalisation Mechanism (REM)*, July 2019

SIRA, Letter to Clayton Utz and Deloitte dated 9 June 2021

SIRA, *Post Implementation Review of the Authorised Health Practitioner (AHP) Framework: Discussion paper*, July 2021

SIRA, *Proposed Draft Motor Accident Guidelines to support model for consultation*, 2021

SIRA, *Reforming insurer profit in compulsory third party (CTP) motor vehicle insurance: Discussion paper*, November 2016

SIRA, *SIRA compliance and enforcement policy*, July 2017

SIRA, *SIRA's response to independent report on internal review*, March 2021

SIRA, *SIRA's answers to questions taken on notice at the Law and Justice Committee's 2020 Review of the Compulsory Third Party Insurance and Lifetime Care and Support schemes (CTP and LTCS) hearing – 26 May 2021*

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

SIRA, *Summary of the SIRA customer experience and health outcomes study*, Undated

Social Research Centre, *SIRA Regulatory Measurement of Customer Experience and Outcomes Study*, November 2020

Taylor Fry, *Review of legal support for people injured in the NSW CTP Scheme*, 3 September 2021

Watts, J., *Report of Review of a Selection of Insurer Files Relating to the Insurer Internal Review Processes*, Undated

3.17.4 Submissions to the Review

ACRS, *Submission to Review*, 2 August 2021

ALA, *Submission to Review*, 2 August 2021

Chesterfield-Evans, A., *Submission to Review*, Undated

[Confidential] Injured person, *Submission to Review*, Undated

[Confidential] Injured person, *Submission to Review*, 9 August 2021

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[Confidential] Law firm, *Submission to Review*, 2 August 2021

ICA, *Submission to Review*, 3 August 2021

IRO, *Submission to Review*, 10 August 2021

Law Society of NSW, *Submission to Review*, 30 July 2021

LTCSA, *Submission to Review*, August 2021

LTCSA, *Supplementary Submission to Review*, 12 August 2021

Motorcycle Council of NSW, *Submission to Review*, August 2021

Osteopathy Australia, *Submission to Review*, July 2021

Road Trauma Support Group NSW, *Submission to Review*, Undated

Stephen Young Lawyers, *Submission to Review*, 2 September 2021

Suncorp, *Submission to Review*, 30 July 2021

Tooth, R., *Submission to Review*, Undated

3.17.5 Submissions to other reviews

ALA, *Submission to Law and Justice Review*, 22 October 2020

ICA, *Supplementary Submission to Law and Justice Review*, 18 December 2020

Law Society of NSW, *Submission to Law and Justice Review*, 9 November 2020

NSW Bar Association, *Submission to Law and Justice Review*, 10 November 2020

NSW Taxi Council, *Submission to Law and Justice Review*, 6 November 2020

SIRA, *Submission to Law and Justice Review*, 28 October 2020

Suncorp, *Submission to Law and Justice Review*, 17 December 2020

3.17.6 Consultation meetings conducted by the Review

Consultation Meeting with Dr Richard Tooth, 4 August 2021
Consultation Meeting with a law firm, 5 August 2021
Consultation Meeting with an injured person, 9 August 2021
Consultation Meeting with an injured person, 9 August 2021
Consultation Meeting with the Law Society of NSW Injury Compensation Committee, 10 August 2021
Consultation Meeting with the Insurance Council of Australia, 11 August 2021
Consultation Meeting with the Australian Lawyers Alliance, 12 August 2021
Consultation Meeting with the Independent Review Office, 12 August 2021
Consultation Meeting with Medical and Allied Health forum, 16 August 2021
Consultation Meeting with the Lifetime Care and Support Authority, 17 August 2021
Consultation Meeting with the Road Trauma Support Group NSW, 19 August 2021
Meeting with Scheme Actuary, 19 August 2021
Meeting with SIRA CTP Premium Committee, 20 August 2021

4. SCHEME IMPLEMENTATION

1 Introduction

Deloitte, in conjunction with Clayton Utz, have been engaged by SIRA on behalf of the Minister for Digital, and Minister for Customer Service, to conduct the three-year independent review required under the MAIA 2017, which came into effect on 1 December 2017. MAIA 2017 replaced the previous MACA 1999. The legislation, regulations and guidelines that define the design of MAIA 2017 are referred to in this section as the "Scheme" and all defined terms have the meaning given to them in the Glossary (Part 6) unless stated otherwise.

An important element of the Act is 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 three years under the MAIA Act. Clayton Utz and Deloitte are appointed by the Minister to undertake that review ("Review"). The policy objectives under section 1.3 of MAIA 2017 are provided in Part 2 'Terms of Reference'.

In this part of the Review, Deloitte focussed on whether the implementation of the Act is meeting the policy objectives of the Scheme. This part covers Deloitte's approach, key findings and recommendations, detailed findings and reliances and limitations.

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2 Approach

The scope of work for both Clayton Utz and Deloitte is outlined in Part 2 'Terms of Reference'.

Deloitte developed KPIs to assess the extent to which the Scheme is achieving intended objectives of MAIA 2017. 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 Scheme are quantifiable in nature. Because of this, Deloitte complements KPIs with qualitative assessments of a range of information provided by SIRA, based on our observations and feedback from this consultation process. Further, it is accepted 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 we used all available information to provide some assessment. Finally, if there are observed material differences in the metric attributable to the same KPI across different information sources, there is discussion of the overlap.

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.

Metric(s) will be assessed for each KPI, and Deloitte will assign a 'Red, Amber, or Green' (RAG) 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. There may still be areas for improvement.

Metric(s) 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 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 my assessment. Some KPIs are considered 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 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. Feedback from the stakeholder consultation was taken into consideration in the analysis.

We have used available qualitative and quantitative Scheme data, provided by SIRA, to validate the objects of MAIA 2017 and assess different aspects of the scheme. The primary sources provided by SIRA used to perform our work were:

- Universal Claims Database (UCD)
- Qlik which is a reporting tool based on the UCD
- CTP Scheme performance reports
- Quarterly CTP Insurer Claims and Experience and Customer Feedback Comparison reports
- Prior reviews of aspects of the Scheme including file reviews and minor injury reviews
- Law and Justice Committee submissions.

We have also used other sources where required in performing our work and the source is stated throughout the report. A comprehensive list of the information and data used is not included in this report due to confidentiality of many documents provided to Deloitte by SIRA.

3 Executive Summary

3.1 Key Findings

Overall, we found that the Scheme is meeting its objectives, for those aspects of the Scheme where there is sufficient experience to date to make an assessment. For some objectives, it is too early to tell, and more claims and disputes etc. information needs to be collected. Processes such as independent claim file reviews are useful for determining whether the Scheme is meeting its objectives. There are some areas for improvement, and these are highlighted through our recommendations and suggestions, with the priority recommendations included below in section 3.2.

Objective	RAG	Key Findings
(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		• 77% of claims first access treatment within 28 days of the injury across the industry since the Scheme incepted, and 90% within 13 weeks indicating the system appears to be encouraging early treatment and care for most injured road users. It is noted that this does not reflect the extent of ongoing financial support which is discussed in objective (b). • The independent claim file review reports found that most people injured in motor vehicle crashes are receiving timely treatment and there is no evidence of significant under treatment in the results overall. However, these reviews were based on an early cohort of claims (the first 1000) and concluded after 2 years. Further claim file reviews are required to understand whether this objective is being met and can be converted to a RAG assessment of green. • Return to work (RTW) at the 4, 13, 26, 52 weeks after receiving benefits was on average worse than SIRA's initial expectations by 25% across all measures. They are also lower than NSW Workers Compensation scheme rates however there are comparability issues to consider.
(b) To provide early and ongoing financial support for persons injured in motor accidents.		• Over the past three years, claim acceptance rates have been in excess of 98%, and 85% of first weekly statutory payments were made within 13 weeks after the date the claim was lodged. Our view is that this provides an appropriate level of *early* financial support. Further analysis and review is required to understand whether the implementation of *ongoing* financial support is meeting objective (b) to reach a RAG assessment of green. • For the most part, benefits are paid consistent with eligible Scheme benefits. We expected and observed a materially higher number of Non-minor not-at-fault injury claims, particularly at longer durations. This is compared to Minor injury claims and At-fault claims due to the benefit limitations and earlier return to work expectations for these claimants. • There are several support mechanisms available to assist claimants throughout their journey, including the insurer claims manager, CTP Assist and a range of information published by SIRA. However, there is room for these mechanisms to be more targetted and effective. • Considering data from 1 December 2017 to 28 February 2021, 7,169 disputes were received according to the Quarterly CTP Insurer Claims and Experience and Customer Feedback Comparison March 2021 report, that is 1 in 5 claims have a dispute against them. In our view, more analysis is needed to understand the root causes of these disputes, especially if they overturn decisions made by the insurers.
(c) To continue to make third-party bodily insurance compulsory for all owners of motor vehicles registered in New South Wales.		• The CTP scheme continues to be mandatory for all NSW vehicle owners. However, it is noted that every year there is a volume of claims associated with unregistered hence uninsured vehicles. There may also be a small percentage of accidents that are not included in our data if both vehicles are unregistered and the police are not involved.

(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.		• Overall, less than one week of household income is required to pay for the average NSW CTP premium, including for low income households. On comparison of the affordability of personal lines insurance policies, NSW CTP premiums are significantly more affordable. • A larger proportion of the total premium payable including GST and levies goes towards claimants. On a prospective basis, the Schedule 1E parameters has been fairly stable over the last 4 years with claims (48%), expenses (12%), profit margin (5%) and Levies and GST (35%) as a proportion of premium including Levies and GST. 17% of total premium is in respect of the Lifetime Care and Support Fund and is included in the Levies and GST component. • TEPL has not yet been enacted to manage profit margins due to the current maturity level of development of claims experience. However per the schedule 1E premium parameters, insurers filed for pricing levels that included an 8% profit margin on total premiums (excluding GST and levies). 73% of total premiums excluding GST and levies goes towards claims. If profit margins are above 10%, the TEPL mechanism may return any excess profits to policyholders and through stakeholder discussions we understand activation of the TEPL mechanism may be considered at the next review. • The REM has been enacted which assists in avoidance behaviour by insurers related to specific high-risk segments to ensure all people of NSW can buy cover at an affordable rate. Decisions regarding REM deficits and surpluses appear to be manged appropriately.
(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.		Overall, we view the Scheme is meeting its objective (e) given: • the entrance of a new insurer into the Scheme, Youi. • opportunities for innovation being created, with the option for insurers to create their own innovations and potentially be rewarded for them. • the Scheme appears to be sustainable for Policyholders, Claimants, Insurers, and the Government.
(f) To deter fraud in connection with compulsory third-party insurance.		Overall, we view the Scheme is not in a position to be meeting this objective. • There is a lack of overall fraud detection and prosecution in the Scheme, and visibility of this. There does not appear to be any published decisions available with regard to cases implementing the penalties and remedies available pursuant to MAIA 2017. These penalties and remedies are not being utilised, or at least visibly utilised, which may result in an increase in fraudulent or false and misleading claims. • There are many barriers that currently exist to identify and detect fraud under the CTP Scheme including the sharing of information between different Scheme participants. Further, there does not appear to be clear accountabilities, roles and responsibilities in respect of fraud deterrence. • We note that SIRA is proactively seeking to enhance its fraud prevention and deterrence capabilities via a data analytics solution which Deloitte are supportive of to help enhance the operation of objective (f).
(g) To encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes.		Overall, we view the Scheme has room for improvement to meet this objective for the following key reasons: • The internal review process for the most part appears to achieve objective (g) particularly given the timeframes imposed. However 50% of internal reviews progressed to the DRS during 2018-2020. 65% of disputes have been finalised by the DRS, and of the finalised disputes, 41% were overturned in favour of the claimant with 55% of insurer

		decisions upheld. Given the infancy of the Scheme, it is difficult to know whether the rate of progression to DRS is driven by internal review processes, claimant behaviour or other factors. • There is room for simplification of key processes and decisions, particularly for certain types of claims. This includes assessment of PAWE and the limited requirements for verification of earnings which creates difficulty in continuing to monitor entitlements and at the same time 'deter fraud'. Simplification may also be brought about through earning capacity decisions, relevant to the post-second entitlement period and other areas. • Several stakeholders submitted that the PIC has been ineffective in resolving disputes in a timely manner. A range of reasons were provided as to why this is the case, including operational concerns such as resourcing, to limitations of operating virtually because of the COVID-19 related lockdowns, to ineffectiveness of the PIC portal as a tool for disseminating information to relevant stakeholders. We understand the PIC has acknowledged these concerns and is aiming to address these issues in the short-term. • There are time limits set on claim lodgement, internal review related communications, and a number of other key processes, however there does not appear to be any time limits on the PIC to resolve disputes. We understand from one submission that under the MACA Scheme there was a requirement for a decision to be made within 15 days of a hearing, and that this requirement has been removed. This extends, not only to decisions pertaining to statutory benefits, but to all certificates issued by the PIC, including medical assessment certificates. It was submitted that it is now frequently the experience of participants in the Scheme that a Certificate is often issued three months after the actual date of assessment noted on the Certificate.
(h) To ensure the collection and use of data to facilitate the effective management of the compulsory third-party insurance scheme.		• Overall, we view the Scheme is meeting its objective (h) since there has been an appropriate level of information and quality of data collected to facilitate effective management. • The implementation of the 2017 Scheme 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. • SIRA provides a Claims Data Manual which sets out the requirements of insurers to provide data that is imported into and stored within the UCD. • SIRA has stated that the data quality is supervised including feedback on identified data quality issues raised in daily error exception and monthly reporting. In order to address errors, insurers must provide improvement plans to address data errors in a timely manner. • An independent claim file review undertaken by John Walsh Centre for Rehabilitation Research (JWCRR); Sydney University and the Centre for Healthcare Resilience and Implementation Science, Australian Institute of Health Innovation (AIHI), Macquarie University also noted '*There is a need for record/data standardisation to occur across the insurers as without this, fully accurate comparisons in how the Act is being implemented are problematic. This could best be supported by the development of guidelines that specify the documents to be used, including where diagnoses must be recorded, and the actual assessment processes to be performed, such for identifying risk of poor recovery.'*

3.2 Key Recommendations

Throughout this report we make several suggestions and recommendations:

- A "Suggestion" is an idea or new approach which if undertaken could potentially improve the operation of the Scheme in line with its objectives however the impact to different stakeholders is not expected to be material.

- A "Recommendation" is intended to have more weight than a suggestion as it will likely improve the operation of the Scheme in line with its objectives and/or relates to a matter of relatively higher materiality and/or risk.

Suggestions and Recommendations are included throughout the report, attached to specific objectives.

We have also included a list of all Suggestions and Recommendations in Part 5.

The table below summarises our priority recommendations in respect of implementation of the Scheme.

Priority Level	Recommendation Label	Priority Recommendations	Objectives Affected
1	Independent Claim File Review	We recommend a process of independent claim file reviews that focus on the following key areas: • given 41% of insurer decisions are overturned, a review of whether claimants were provided adequate treatment and care (objective (a)), and ongoing financial support (objective (b)), for their particular needs and circumstances, focussing on both declined claims, and claims that were not disputed at the DRS, however displayed similar characteristics to those that were overturned in favour of the claimant at the DRS to further glean insights into the appropriateness of insurer internal reviews (IIRs). • to understand RTW rates better and ascertain whether their current level is a result of the treatment and care received. • the extent to which actual treatment and care provided to injured persons differs from medical advice, and the extent to which medical advice differs where multiple opinions are sought. • minor injury assessments are completed until up to around three months after being reported which can result in reclassification of claims. Given also that 50% of internal reviews were referred to the DRS in 2018-2020, and the operational and legal costs incurred for these claims, we recommend an independent claim file review is conducted to understand the drivers of minor injury claim disputes and the associated cost of these. While the claims portfolio appears to have been fairly represented through existing independent claim file reviews, a deeper focus on reviewing claims in these key areas will provide the greatest insight for further improvement to the Scheme. We are of the position that SIRA is best placed to decide if SIRA engages an external independent body or if SIRA, as an independent authority, undertakes a review.	(a) (b)
2	Internal Review Case Selection	We recommend that a review is conducted into the types of claims that are suitable for internal review compared to those that should proceed directly to the PIC. Medical disputes relating to whole person impairment appears to be one example where disputes should proceed directly to the PIC. The decision on the types of claims that may be considered suitable or optional to the claimant should balance the different Scheme objectives.	(g)
3	PIC Improvements	We understand the PIC has acknowledged concerns that the PIC portal has been ineffective as a tool to disseminate required information to relevant stakeholders and is aiming to address these issues in the short-term. We are supportive of these activities being conducted in the short-term.	(g)

		There are time limits set on claim lodgement, internal review related communications, and a number of other key processes, however, there does not appear to be any time limits on the PIC to resolve disputes. We recommend setting KPIs for the PIC including targets for resolution of disputes (potentially set differently allowing for case type or complexity) within a certain time limit, and monitor the turnaround time (number of days) for the PIC to make a decision. It is noted that the PIC is not governed by the MAIA Act (2017), however it is an integral part of the Scheme. Thus, this recommendation would be appropriate for the Initial Review of the Rules of the PIC of NSW being undertaken from September 2021 to the first half of 2022.	
4	Claimant understanding of scheme and entitlements	We recommend, in-line with an option suggested by Taylor Fry in their Review of Legal Support, for CTP Assist to have an expanded role and be more proactively promoted as the first point of call for injured people. This is to ensure that more claimants are aware of all their benefits, including regarding disputes, and can navigate their claims journey more effectively. We recommend that SIRA investigate the level of understanding by claimants regarding the scheme and its entitlements, including disputation paths. Taylor Fry's report 'Review of Legal Supports' dated 3 September 2021 recommends a comprehensive survey of claimants would be suitable to achieve this.	(b) (g)
5	CTP Assist Complex Claim Team	A review of whether a complex claims case team with expertise in supporting matters such as weekly benefit calculations, would further enhance the capability of CTP Assist, in order to help injured persons better navigate the NSW CTP Scheme and understand their benefit entitlements to promote optimum recovery. This recommendation is in complement to Recommendation 45 of Clayton Utz's analysis.	(b)
6	Additional Monitoring	SIRA monitors the proportion of claimants on benefits at key milestones including 13, 26 and 52 weeks, which reveals benefits are generally being paid consistent with legislative requirements and provides for more benefits to be paid to more severely injured claimants. We recommend monitoring of the proportion of **claimants that have not recovered or been able to return to work** (not just those on benefits) from their injury and have **not** been paid benefits within each of the categories considered. We would expect this proportion to be small, except perhaps for minor and at-fault / mostly at-fault claims where benefits entitlements are limited, however it is this subset of claims that are potentially not receiving ongoing financial support that may be in need. We recommend that SIRA make it a requirement that insurers accurately record for each claim the 'Interpreter Required' field, which may be used to support analysis of relative claims frequency by different Scheme participants. Monitor a range of fraud specific metrics including investigations, prosecutions, fraud recovery rates, and reasons for withdrawal of claims. This is discussed further in Suggestion 28. Monitor the number or proportion of applications for additional costs outside what is permitted by the Regulations (16 monetary units which is currently the equivalent of $1,660.16), where it is asserted that the matter involves 'exceptional circumstances' under s 8.10(4)(b), to gain insight into the nature of claims where this is most prevalent and therefore whether there are areas to improve in Scheme design and / or operation. Monitor a number of key aspects related to claim disputes: • the number of disputes which progress from internal review to PIC in aggregate and for more granular reasons including WPI assessments, fault status, benefit types, and other key reasons etc.	(b) (d) (f) (g) (g)

		• the number of notices issued to claimants where the insurer views the claimant is in breach of the laws and regulations, and the number of insurer applications to the PIC which allows insurers to recover some legal costs. • the number and duration of matters in backlog that are currently before the PIC (formerly DRS). • Cost of insurer internal reviews – average cost per insurer internal review as a proportion of average claim cost for claims that are settled via internal review and do not progress to PIC. • Settlements with or without dispute – costs of settlements for claims with a dispute compared to claims without a dispute.	
7	TEPL	We recommend that SIRA maintains its discretion to trigger the TEPL mechanism, with due reference to advice from the scheme Actuary and Premium Committee. We are supportive of comments made by SIRA's chief executive at the Law and Justice Committee hearings that activation of the TEPL mechanism will be conducted at interim annual reviews once desired confidence levels are achieved.	(d)
8	Vulnerable Persons	Conduct another review into the reasons for markedly lower claims frequency in the Scheme compared to the original Schedule 1E parameters. For example, whether there is different experience observed in data from hospitals across different geographical locations, which may help create a link to claim reporting patterns for vulnerable people such as those who require an interpreter or other assistance.	(d)
9	Fraud – Information	We recommend that SIRA engage with insurers and NSW Police to identify the most efficient way of accessing the information and data pertaining to potentially fraudulent claims, and to the extent it will be released to the claimant. For example, a portal system could be set up for release of all police investigations relating to a matter in which a CTP claim is made, once investigations are completed. This would avoid the need for making multiple Government Information (Public Access) Act 2009 (GIPA) applications which require authorisation by the parties and lead to highly relevant police outcomes, particularly with regard to suspected fraudulent claims, being available to insurers in the early stages of investigating a claim.	(f)
10	Fraud – Responsibilities	We recommend a thorough investigation into the extent and nature of fraud and potential fraud which will then form the basis of accountabilities, roles and responsibilities in respect of fraud deterrence across all Scheme participants.	(f)

4 Detailed Findings

4.1 Objective (a): Early and Appropriate Treatment and Care

Table 4.1.1: Overall assessment of the implementation of Scheme objective (a)

Objective	Overall RAG
(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.	
a.1: To encourage early treatment and care to achieve optimum recovery of persons from injuries sustained in motor accidents	
a.2: To encourage appropriate treatment and care to achieve optimum recovery of persons from injuries sustained in motor accidents	
a.3: To maximise claimants return to work or other activities	

Overall, we view the Scheme has **room for improvement** to meet objective (a).

61% of claimants are reporting their claim in the first month, which is an indicator that the majority of claimants are seeking early support. Since the Scheme incepted, 77% of claims first access treatment within 28 days of the injury, and 90% within 13 weeks, indicating the system appears to be encouraging early treatment and care for most injured road users. It is noted that this does not reflect the extent of ongoing support which is discussed in objective (b).

The Return to Work (RTW) rates at 4, 13, 26, 52 weeks after receiving benefits was on average worse than SIRA's initial expectations by 25% across all measures. They are also lower than NSW Workers Compensation scheme rates however there are comparability issues to consider, not least the question of injury severity for example. It is also possible that the lodgement timing requirement for common law benefits could be acting as a disincentive to RTW, since lodgement of these claims occur at 20 months for claimants with WPI <= 10%, and in the meantime the claimant may be in receipt of statutory benefits. It is our view that there is room to improve and incentivise RTW rates.

There are other areas for improvement, and the detailed recommendations for these are outlined further below:

- the ongoing use of independent claim file reviews as this provides the most effective means of assessing this objective. Some key areas we recommend that the independent claim file review cover includes declined claims for treatment and care benefits, claims that go through the dispute resolution process, and claims that are 'cash settled'. While the claims portfolio appears to have been fairly represented through existing independent claim file reviews, a deeper focus on reviewing claims in these key areas will provide the greatest insight for further improvement to the Scheme. We are of the position that SIRA is best placed to decide if SIRA engages an external independent body or if SIRA, as an independent authority, undertakes a review.

- a review of whether a complex claims case team with expertise in supporting matters such as weekly benefit calculations, would further enhance the capability of CTP Assist, in order to help injured persons better navigate the NSW CTP Scheme and understand their benefit entitlements to promote optimum recovery. This recommendation is in complement to Recommendation 45 of Clayton Utz's analysis.
- In line with an option suggested by Taylor Fry in their Review of Legal Support, for CTP Assist to have an expanded role and be more proactively promoted as the first point of call for injured people. This is to ensure that more claimants are aware of all their benefits, including regarding disputes, and can navigate their claims journey.
- conduct a review to understand best practice recovery plan processes and documentation for use across the industry.
- we support SIRA's plans to improve definitions and measurements of RTW rates, and suggest this is extended to include stay at work, and return to pre-accident activities capacity. While RTW rates are unfavourable it is difficult to ascertain whether this is a result of the treatment and care received, and we view that the claim file review recommended above should help provide a robust view of this.

We observed there is a volume of claims that transition between different severity levels e.g. minor to non-minor. The 31 December 2020 Scheme Actuary report shows there are on average 200 claims per quarter (approximately 13%) transitioning out of the not at-fault minor injury claim type into other claim types. Similarly, there are around 190 claims per quarter (approximately 20%) transitioning into the not at-fault non-minor injury category from the not at-fault minor injury category. Some claims naturally transition as the severity of the claim increases, however, some may have been misidentified. There is a question about whether some claimants received the appropriate treatment given incorrect classification of the injury severity. There may be an opportunity to improve the triage of claims into different recovery risk levels, however this has not been made clear or been supported through specific information provided. The independent claims file reviews may support this work.

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 considered a range of metrics which gives context to the claim process including timeliness of claim events such as the reporting of claims, liability decisions, treatment, and payments.

Table 4.1.2: Detailed assessment by KPI of the implementation of Scheme sub-objective a.1

KPI TITLE	DESCRIPTION	RAG	ANALYSIS	RECOMMENDATIONS
TIMELINESS OF CLAIM REPORTS	On average, claims are lodged within 3 months of the accident date, or earlier.		As per the Motor Accident Guidelines 4.15, to be eligible for statutory benefits, the claimant must submit their claim within 3 months. To be eligible for weekly benefits, the claimant must submit their claim within 28 days. The percentage of claims reported within 28 days after the accident date was 61%, and by lodgement year was 59% in 2018, 60% in 2019, and 63% in 2020. Approximately 9% of claims are lodged more than 3 months after the accident date, and about a third of these appear to have been accepted.	

			The mean number of days between the accident date and the lodgement date of claims was 39 days in 2018, 47 days in 2019, and 55 days in 2020. The mode was 28 days in 2018, 27 days in 2019, and 7 days in 2020. The median was 26 days in 2018, 24 days in 2019, and 23 days in 2020. The median is the most robust of these averages, with a narrow range of 23-26 days, whereas the mean increased year on year due to large outliers in more recent years and the mode decreased by 3 weeks in 2020 *(UCD).* Whilst the reporting of claims is driven by the claimant, not the insurer or SIRA, the fact that 61% of claimants are reporting their claim in the first month is an indicator that the majority of claimants are seeking *early* support.	
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.		Insurers can approve access to treatment before a claim is made and after notification of injury if treatment is within 28 days from the date of motor accident (Section 4.74 and 4.75 of the Motor Accident Guideline). There is no legislated timeframe for a claimant to first access treatment. 77% of claims first access treatment within 28 days of the injury across the industry since the Scheme incepted. 93% of claims first access treatment within 13 weeks of the injury across the industry since the Scheme incepted. *(Qlik, Time duration measures 1 of 3)*. On average, claimants first access treatment and care 2.3 weeks prior to lodging a claim *(Qlik, Time duration measures 2 of 3)*. The system therefore appears to be encouraging early treatment and care for most injured road users. It is noted that this does not reflect the extent of ongoing financial support, and whether this early treatment and care achieves optimum recovery of injured persons is considered through other measures.	N/A
TIMELINESS OF RECOVERY PLANS	Percentage of recovery plans completed within 12		As per the Motor Accident Guidelines 4.86, a recovery plan must be completed within 28 days of the claim being made or within 28 days of the claimant's initial discharge from	**Suggestion 2:** From a health outcomes point of view, recovery plans can be beneficial to the

	weeks of claim lodgement.	hospital in circumstances where the claimant has been admitted to hospital within two days of the date of the motor accident and remained in hospital for a period of not less than three continuous weeks, whichever is the later. The recovery plan must be reviewed no less than at 12 weekly intervals or as pertinent changes occur. The percentage of claims with a recovery plan review date for an initial recovery plan (or noting that a recovery plan is not required) that is within 3 months of claim lodgement was 72% in 2018, 92% in 2019 and 88% in 2020. However, an initial recovery plan established within 28 days as outlined above (or a note stating that a recovery plan is not required) is only present on about 60% of claims, after removing interstate claims, fatalities and compensation claims to relatives *(UCD)*. This aligns with the findings of the independent claim file review, which found that for almost half of injured people, a recovery plan could not be located. The report also found that: • From a health outcomes point of view, people with a high risk of poor recovery require a more structured and extensive recovery plan, noting that for some claims a risk assessment and recovery plan is not required. • That there was considerable variation in screening for risk of non-recovery and therefore that processes are not standardised. • The audit showed incomplete documentation of potential for poor recovery. The ICA noted during stakeholder consultations that a recovery plan is developed after an injured person has accessed treatment and does not reflect whether they have accessed that treatment early.	claimant. Further, given that there are reportedly inconsistent processes for the implementation of recovery plans across the Scheme, we suggest a review is conducted to understand best practice recovery plan processes and documentation and share this with all key stakeholders. This suggestion is aligned and in complement to Recommendation 10 of Clayton Utz's analysis.

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 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, and we have therefore leveraged the results of reviews that have been conducted by other organisations since Scheme inception, the results of which may be considered in our analysis.

Declinatures: 69.0% of claimants were declined statutory benefits after being on benefits for 26 weeks.This includes claimants with statutory liability status accepted or rejected after 26 weeks where 'accepted' includes partially accepted with contributory negligence after 26 weeks (94.3% of all claimants). For minor injuries and at-fault or mostly at-fault claims, these percentages are 99.9% and 99.8% respectively. For other claims , the declinature rate is 31.2% *(Qlik, Statutory Benefits 5 of 6)*. It is noted that the data collected for declinatures is for both weekly and treatment and care benefits..

Recommendation 3: Collect data separately for declinatures of weekly benefits and treatment and care benefits to monitor the declinature rates for these benefits for not at-fault non-minor claimants, after being on benefits for 26 weeks.

Table 4.1.3: Detailed assessment by KPI of the implementation of Scheme sub-objective a.2

KPI TITLE	DESCRIPTION	RAG	ANALYSIS	RECOMMENDATIONS
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).		Deloitte was not provided with information to enable assessment of this metric. A Certificate of Fitness is required to submit a claim (except for funeral expense claims). Deloitte views this is a sensible requirement as medical advice early on in a claimant's journey should assist in ensuring the claimant receives appropriate treatment and care, consistent with the Scheme objective. Therefore, we expected that this metric would be very high and close to 100%. Through stakeholder discussions it was indicated that there have been quite varied medical opinions in some instances, and that the documentation of this has not been thorough.	**Suggestion 4:** Make available the data to measure this KPI. Further, we suggest monitoring the extent to which actual treatment and care provided to injured persons differs from medical advice, and the extent to which medical advice differs where multiple opinions are sought. This may be an area which can be included as part of claim file reviews included as part of other recommendations.
COMPLAINT VOLUMES	Percentage of complaints per claim lodged referred to SIRA's supervision teams.		While complaints provide one view of a claimant's experience when interacting with the NSW CTP Scheme, and not necessarily a medical or legal view, it is an important view, given injured persons are at the centre of the purpose of the Scheme. It may also assist in further refining the Scheme over time. The percentage of complaints per claim referred to SIRA's supervision teams was 6% in the industry over 2019 and 2020. There are differences by insurer in complaint volume with a range of 2-8% *(CTP Insurer Claims and Experience and Customer Feedback Comparison reports & Qlik, Claims overview 1 of 3)*. This indicates that the vast majority of claimants have not made a complaint.	**Suggestion 5:** While complaints emanate from a small proportion of claims, we suggest more detailed monitoring and analysis of the underlying drivers of complaints to understand the extent and situations in which injured persons have not viewed their treatment and care was appropriate. **Suggestion 6:** In the 'CTP Insurer Claims Experience and Customer Feedback Comparison', we suggest that complaint volumes are expressed as a percentage of

			The complaints encompass claims decisions, delays, management, service, and other types of complaints. The complaints information provided in monitoring does not give further insights.	lodged claims rather than on all Green Slips. This would provide a more meaningful statistic since most complaints are in respect of lodged claims.
CUSTOMER SATISFACTION	CTP Assist Net Promoter Score (NPS) and customer effort scores (CES).		CTP Assist is an important mechanism to encourage appropriate treatment and care, by helping injured persons to navigate the NSW CTP Scheme and understand their benefit entitlements. CTP Assist should therefore aid in promoting optimum recovery of injured persons. The Net Promoter Score (NPS) measures how likely a customer is to recommend CTP Assist to others. It is calculated using a standard formula: the percentage of customers that score the service nine or ten out of ten ('promoters') less the percentage who scored it at six or less ('detractors'). Other scores are represented as 'passive'. Scores are assessed separately for assistance provided via Digital (online) compared to Voice (over the phone) service. The 4-month rolling average to the June month Voice NPS were 43, 53 and 67 over 2018-2020 respectively according to the SIRA Annual Reports. According to the Australian NPS Pulse Check, CTP Assist is as at June 2020 a national leader in delivering a great customer experience. There has been a positive trend in the NPS scores over time and there is a large proportion of promoters in comparison to detractors. The Customer Effort Score (CES) measures how easy it is for a customer to get the help they need. The score is out of 5. The 4-month rolling average to the June month Voice Customer Effort Scores (CES) were 4, 4.1 and 4.4 for 2018-2020 respectively according to the SIRA Annual Reports. The CES also has a positive trend and has maintained high scores over time *(SIRA Annual Reports)*. The CTP Assist Digital Team commenced touchpoint surveys in October 2019 with a small volume of responses for the first few months since inception. As such, there is no statistically reliable data for Digital prior to 2020. The volume of responses is also lower than the Voice team, presenting volatility to the scores over time. From the Colmar Brunton CTP Claimant Experience Research Q4 Report dated January 2021, the following was noted:	**Recommendation 7:** NPS and CES scores indicate that CTP Assist has been an effective mechanism. Some stakeholder submissions and discussions indicated some areas for improvement in CTP Assist, including the accuracy of information provided, primarily related to more complex matters. We recommend a review of whether a complex claims case team with expertise in supporting matters such as weekly benefit calculations, would further enhance the capability of CTP Assist, in order to help injured persons better navigate the NSW CTP Scheme and understand their benefit entitlements. This recommendation is in complement to Recommendation 45 of Clayton Utz's analysis. **Recommendation 8:** We recommend, in-line with an option suggested by Taylor Fry in their Review of Legal Support, for CTP Assist to have an expanded role and be more proactively promoted as the first point of call for injured people. This is to ensure that more claimants are aware of all their benefits, including regarding disputes, and can navigate their claims journey more effectively.

		- On aspects of CTP Assist: "Overall, the experience with CTP Assist was positive. All aspects measured, achieved a mean score of 7.8 or above. Satisfaction with the professionalism of staff (8.5) remains strong and is a relative strength, while opportunity exists to improve how long it takes to receive any follow-up information." - On aspects of CTP Assist Representative: "CTP Assist representatives received strong ratings, with the majority of surveyed claimants expressing high levels of satisfaction (ratings of 8 out of 10 or higher) across all attributes. Active listening and demonstrating an understanding of how claimants feel was a relative strength of these representatives, as was their ability to clearly differentiate their role from the role of the insurer (71% were highly satisfied with both attributes)." - On contacting CTP Assist for making a claim and satisfaction between Voice/Digital: "Two thirds (66%) contacted CTP Assist during their application for Statutory Benefits. Among those who made contact, claimants of the phone service were the most satisfied (6.6), while users of the website were considerably less satisfied (5.6)." - On satisfaction of CTP Assist as part of claim: "Overall satisfaction with the CTP Assist team was mixed, with a mean score of 6.2 out of 10. Opportunity exists for CTP Assist to review how proactively it provides advice and how easy it is to understand information sources. A notable minority (26%) indicated some degree of dissatisfaction with both aspects." The findings of the report reinforce that there can be improvements for the Digital team and remains further improvement for CTP Assist as a whole. It is understood from Taylor Fry's Review of Legal Support report dated 3 September 2021 that CTP Assist have a systematic outbound contact program for claims who have post-26 week entitlements, which is aimed to gauge claimant awareness and measure progress of damages claims. It was also stated that many claimants were unaware of CTP Assist or were told and had forgotten.

Qualitative indicators: In the interim report titled New Compulsory Third Party Reform Evaluation Project on December 2020, self-reported qualitative indicators have seen improvements in the MAIA 2017 Scheme in comparison to the MACA 1999 Scheme at the following levels:

1. General health scores: the rate of negatively reported health (defined as Fair to Poor reported health, where the possible reported health outcomes ranged from Poor, Fair, Good, Very Good and Excellent) was higher for MACA 1999 claimants compared to MAIA 2017 claimants at each time point including pre-injury (6.3% vs 5.7%), baseline (59% vs 37.3%) and 6-months post-injury (20% vs 15.1%).
2. Pain scores: a higher proportion of MAIA 2017 claimants reported having pain soon after their injury than MACA 1999 claimants (97% vs 87%), however fewer reported pain 6-months later (47% vs 67%).
3. Mental health scores: Both groups reported higher improvements at six months post-injury, with a bigger improvement reported by MAIA 2017 claimants.

Independent Claim File Review: A review was undertaken over a two-year period by two organisations - the John Walsh Centre for Rehabilitation Research (JWCRR); Sydney University and the Centre for Healthcare Resilience and Implementation Science, Australian Institute of Health Innovation (AIHI), Macquarie University. The review monitored the initial cohort of injured people utilising the 2017 CTP scheme, particularly with reference to achieving the objects of the Act and the intentions of CTP scheme reform. The review focussed on claimant recovery and return to work or other activities for 1000 injured people, of which 500 files were allocated to each reviewing organisation by the State Insurance Regulatory Authority (SIRA). An independent review has been conducted on the application of the minor injury threshold and other issues such as treatments provided. The results from JWCRR and AIHI reviews are broadly similar and we include here some of the JWCRR results. The 500 claims allocated to JWCRR provided a reasonable cross section of claimants in the Scheme, with 424 (85%) of the claims available for audit:

- "By two-years post injury, a total of 242 cases (57%) had been determined as minor and 182 (43%) had been determined as non-minor."
- "Of the non-minor injuries 49% were "physical", 18% were "psychological", 28% were both physical and psychological (and for 5% the nature of the injury was unclear). Over the two-years of the audit, the injury decision changed from minor to non-minor for a total of 23 cases (5%)."
- "At two-years after injury 25% of claims were shown as still open. However, as expected about 60% of claims were closed or settled by one year after injury."
- "The most frequent physical injury type recorded at each time point is "pain", with many physical "injuries" defined only with reference to pain. Thus, there is no recorded formal diagnosis."

The independent claim file review report found that most people injured in motor vehicle crashes are receiving timely treatment and there is no evidence of significant under treatment in the results overall. The audit showed incomplete documentation of potential for poor recovery. For almost half of injured people, a recovery plan could not be located. It is noted that for some claims a risk assessment and recovery plan is not required.

Internal insurer reviews occurred in about 20% of claims and only a small percentage of decisions were reversed after internal review. These were relatively more frequent in those with non-minor injuries. This indicates that for most claims included in the file review, claimants appear to be receiving early and appropriate treatment consistent with Scheme objective (a). However, the report did not consider dispute decisions that are also subject to external review. Overall, in the first three years of the Scheme there have been over 35,000 claims and roughly 20% of these have been disputed (55% of which had insurer decision upheld). These results are broadly consistent with the independent claim file review.

Finally, the report states that a limitation of it, is that a small number of cases were settled by the insurers, with an agreed amount of payment, and this information was not recorded as part of the routine data collection, as it was not part of the agreed data collection tool. Further, it is not known how many of these cases were contained in the allocated files. This means that some cash settlement cases may not have had a complete record of information such as treatment and RTW status on file.

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 by 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 is currently in progress as at 1 April 2021 which may impact assessment of this object in future.

Table 4.1.4: Detailed assessment by KPI of the implementation of Scheme sub-objective a.3

KPI TITLE	DESCRIPTION	RAG	ANALYSIS	RECOMMENDATIONS
RTW MEASURES	Percentage of claims RTW at the following number of weeks after first receiving benefits (4, 13, 26, 52).		RTW rates help to understand the proportion of claimants that returned to work in any capacity, a certain number of weeks after first receiving benefits. The percentage of claims by cease work month since scheme inception that had RTW at the 4, 13, 26, 52 weeks after receiving benefits was on average 24%, 42%, 58% and 60%. This varies by insurer, and we observed one insurer with RTW rates which deteriorated significantly over time. SIRA's expectations for the RTW rates 35%, 60%, 75% and 80% at 4, 13, 26 and 52 weeks. This indicates that the Scheme is performing worse than expectations by approximately 25% on average across all measures *(Insurer Scorecard June 2020)*. By comparison, the RTW rates in the NSW Workers Compensation scheme are 62%, 76%, 81% and 87% at the same points *(SIRA Discussion paper – measuring return to work dated December 2019)*. We understand however that the definition of RTW in the Schemes differ as do the injury profile of claimants. We understand that both Scheme definitions include RTW in any capacity, however there may be other differences including the accident year cohort of claims included and the start date for the duration calculation. Some stakeholder submissions and discussions suggested that there is not significant incentive to RTW for claimants that seek common law benefits, since lodgement of these claims occur after 20 months for claimants with WPI <= 10%, and in the meantime the claimant may be in receipt of statutory benefits.	**Suggestion 9:** We understand SIRA is currently working to develop RTW definitions and measures which may be aligned across the CTP and Workers' Compensation schemes. This will allow more effective measurement and monitoring of RTW rates to produce insights that may inform improvements which provide better outcomes for injured persons. Deloitte are supportive of this work.

			We observed there is a volume of claims that transition between different severity levels e.g. minor to non-minor. The 31 December 2020 Scheme Actuary report shows there are on average 200 claims per quarter transitioning out of the not at-fault minor injury claim type into other claim types. Similarly, there are around 190 claims per quarter transitioning into the not at-fault non-minor injury category from the not at-fault minor injury category. Some claims naturally transition as the severity of the claim increases, however, some may have been misidentified. There is a question about whether some claimants received the appropriate treatment given incorrect classification of the injury severity. There may be an opportunity to improve the triage of claims into different risk recovery levels, however this has not been made clear or been supported through specific information provided. The independent claims file reviews may support this work.	
STAY AT WORK MEASURES	Percentage of claims stay at work at the following number of weeks after first receiving benefits (4, 13, 26, 52).		The percentage of claims that had stayed at work at 4, 13, 26, 52 weeks after receiving benefits was 58%, 45%, 46% and 33% as at 30 June 2020 *(Insurer Scorecard June 2020)*. This compares to the stayed at work rate of the Workers Compensation scheme at 40% to 44% in between the financial years from 2014/15 - 2018/19 (and that rates for 4, 13 and 26 weeks were not measured in the SIRA Discussion paper – measuring return to work). We note there are differences in injury profiles between the CTP and WC schemes.	**Suggestion 10:** We suggest that as part of the development of RTW measures, that stay at work measures for 4, 13, 26 and 52 weeks are included as part of that process.
RETURN TO EVERYDAY LIFE RATE FOR OTHER ACTIVITIES	Return to everyday activities including work around the house, social activities, and volunteering.		In the 'SIRA Regulatory Measurement of Customer Experience and Outcomes Study' report dated November 2020, a survey was conducted in between 15 June and 21 July 2020 for 893 CTP claimants who had been dealing with their insurance company from 1 April 2019 to 31 March 2020. When asked the question 'In the last week, how often has your injury resulted in you being unable to do the following', the percentage of injuries resulting in being unable to complete an activity all / most / some of the time was:	**Suggestion 11:** We suggest that as part of SIRA's development of RTW measures, that return to pre-accident activities capacity is measured, including everyday activities but also activities that the injured had usually partaken in and enjoyed pre-accident (or continue to produce this report annually).

		- 41% for participation in regular activities such as work or study - 38% for participation in normal household activities - 38% for participation in normal social activities with friends, family, or neighbours - 38% to do simple actions such as standing, reaching, sitting, or walking - 29% to do activities that require concentration such as reading, watching TV, or driving - 26% to do activities that require physical co-ordination such as getting dressed, eating, making dinner or cooking These rates are similar for minimal and moderate severity injuries, whereas severe injuries have higher rates given the nature of the injuries.

4.2 Objective (b): Early and Ongoing Financial Support

Table 4.2.1: Overall assessment of the implementation of Scheme objective (b)

Objective	Overall RAG
(b) is to provide early and ongoing financial support for persons injured in motor accidents	
b.1: To provide early financial support for persons injured in motor accidents	
b.2: To provide ongoing financial support for persons injured in motor accidents	

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

Overall, we view the Scheme has **room for improvement** to meet objective (b). Although the Scheme appears to be meeting the objective of providing *early* financial support, more evidence is needed to support a green RAG assessment for the objective to meet *ongoing* financial support. We have recommended further analyses and claim file reviews below.

- Over the past three years, claim acceptance rates have been in excess of 98%, and 85% of first weekly statutory payments were made within 13 weeks after the date the claim was lodged. We view this provides an appropriate level to provide early financial support.
- There are several support mechanisms available to assist claimants through their journey, including the insurer claims manager, CTP Assist and a range of information published by SIRA.
- Considering data from 1 December 2017 to 28 February 2021, 7,169 disputes were received according to the Quarterly CTP Insurer Claims and Experience and Customer Feedback Comparison March 2021 report. Of these disputes, 2854 or 40% have been determined, with 41% of insurer decisions being overturned (55% are upheld). In respect of weekly benefit payment amounts, 55% of insurer decisions are overturned and 45% are upheld. Given that for the 80% majority of claimants there is no dispute, the Scheme appears to be meeting its objective of providing ongoing financial support for persons injured in motor accidents. However, this may also reflect the reduction in legal representation of claimants which is discussed under Objective (g).

However there are areas for improvement:

- We recommend analyses of the profile of declined claims, particularly those that lodged a late claim to understand whether these are vulnerable customers that need assistance, or due to another underlying reason, which will assist in assessing whether the current measures are sufficient for ensuring injured road users understand how to access the system and their entitlements. Some stakeholders submitted they had observed poor literacy and an inability to use email in some claimants. Some stakeholders submitted that some claimants have difficulty completing claim forms in the first month after the injury due to the physical and psychological effects of pain and pain medication, which may be exacerbated by more complex aspects such as calculations of weekly income earnings.
- Given 41% of insurer decisions are overturned, we recommend an independent claim file review consider whether claimants were provided adequate treatment and care (objective (a)), and ongoing financial support (objective (b)), for their particular needs and circumstances, focussing on claims that were not disputed at the DRS, however displayed similar characteristics to those that were overturned in favour of the claimant at the DRS to further glean insights into the appropriateness of internal reviews.

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

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.

Table 4.2.2: Detailed assessment by KPI of the implementation of Scheme sub-objective b.1

KPI TITLE	DESCRIPTION	RAG	ANALYSIS	RECOMMENDATIONS
CLAIM ACCEPTANCE RATES	The rate of statutory benefits claims accepted by insurers. (Duplicated from KPIs in objective (a))		Claim acceptance rates were 98.0% in 2020 and 98.8% in 2019 across the Scheme. Claim acceptance rates vary by insurer with the lowest observed rate being 93.8% *(CTP Insurer Claims and Experience and Customer Feedback Comparison December 2020).* Key reasons claims were declined is that the claim was lodged more than 90 days after the accident, or insufficient information was provided to the insurer. Overall, we view the observed levels of claim acceptance rates provide an appropriate level to provide early financial support. Based on information provided by SIRA officers, all CTP Assist services can be provided through an interpreter or translated from English into a community language. SIRA has also developed a 12-part CTP animation series which has been translated into Arabic, Cantonese, Mandarin, Korean, Vietnamese and Greek to make them more accessible to the community. The CTP video campaign which was featured on YouTube and Facebook had 303k 15-second video views. It is noted that 3 of the 12 parts have been removed relating to disputes when the PIC was created. Vendor details have been provided to the PIC so that it can update two animations if it so chooses. SIRA ensures that their website meets Content Accessibility Guidelines (WCAG) 2.0 standards, a series of international standards from the World Wide Web Consortium, to at least level AA compliance so that people of all abilities, including older people and those with visual, hearing, cognitive or motor impairments can access their information and services.	**Recommendation 12:** We recommend analysis of the profile of declined claims, particularly claims that were lodged late to understand whether these are vulnerable customers that needed greater assistance during the lodgement process, or if there are other systemic underlying reasons. This will assist in assessing whether the current measures are sufficient for ensuring injured road users understand how to access the system and their entitlements. We note that Clayton Utz Recommendations 5 and 6, if adopted, are intended to reduce the rates of declinature of treatment and care benefits. **Suggestion 13:** We suggest that SIRA updates the animation series to include information on the PIC to assist potential claimants navigate this element of the Scheme.

		Some stakeholders submitted they had observed poor literacy and an inability to use email in some claimants. Some stakeholders submitted that some claimants have difficulty completing claim forms in the first month after the injury due to the physical and psychological effects of pain and pain medication, which may be exacerbated by more complex aspects such as calculations of weekly income earnings.	
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 first liability decision is made Percentage of claims with less than a 90 day interval between the date the claim is reported and the date the second liability decision is made	According to Section 6.19 of the Act and Section 4.35 of the Motor Accident Guidelines, an insurer must: 1. Give notice for statutory benefits for the first 26 weeks after the accident within four weeks after a claimant makes a claim for statutory benefits. 2. Give notice for statutory benefits for the first 26 weeks after the accident within three months after a claimant makes a claim for statutory benefits. The Act states that if the insurer fails to notify the claimant in accordance with this section, the insurer is taken to have accepted liability for the statutory benefits concerned. (MAIA s6.19(4)) SIRA has stated that whilst data surrounding the timing of the first and second liability were previously collected separately, the data is no longer being collected in this format. Hence, in forming the metrics below, the data includes a blend of the first and second liability decision i.e. if there was a second liability decision made, this time would be recorded and replace the first liability decision made. Approximately 99% of claims have had a liability decision made within 90 days of the claim lodgement date. This is consistent by lodgement year (99.1%, 99.3% and 98.4% 2018/19/20) *(Qlik, Time duration measures 1 of 3)*. Whilst it is apparent that a liability decision is made within 90 days, signalling compliance with the timeliness of second liability decisions, we are unable to ascertain whether insurers are meeting legislated timeframes for the first liability decision as discussed above.	**Recommendation 14:** We recommend the collection of data on the timing of the first and second liability decision separately, to monitor compliance with both the first and second liability decision as per 6.19 of the Act.

TIMELINESS OF INCOME SUPPORT PAYMENTS	Percentage of claims with time between date of lodgement and first income support benefit less than 13 weeks.		Section 4.43 of the Motor Accident Guidelines state that after the acceptance of liability for insurance benefits, weekly payments may be payable, including an interim payment (i.e. where pre-accident weekly earnings cannot yet be determined) for the first 13 weeks. To assist in assessing the provision of early financial support, we considered the extent to which weekly payments were made by 13 weeks after claim lodgement, even if pre-accident weekly earnings have not yet been determined. We note that there is no legislated requirement for income payments to be paid within 13 weeks. Over the past three years, 85.1% of first weekly statutory payments were made within 13 weeks of date after the claim was lodged. By insurer there was a range of 80-90% of payments made within 13 weeks. By claim lodgement year, this percentage has improved from 80.1% in 2018, to 84.7% and 90.8% in 2019 and 2020. We note that the more recent years are less developed, as only claimants who have received their first weekly statutory payment are included in these figures, therefore these figures may change over time *(Qlik, Time duration measures 2 of 3)*. The ICA has noted that insurers view that provisions are complex and believe that simplification would improve claimant and insurer understanding, decision making and claimant experience. The Law Society has also stated that PAWE has become one of the most complex issues in the CTP scheme and that legal representatives should be able to assist claimants with PAWE and weekly payment disputes.	We support Recommendation 16 of Clayton Utz's analysis that 'SIRA should amend the Guidelines to clarify that the relevant insurer must begin weekly payments of statutory benefits immediately after determining that a claimant is an earner entitled to weekly payments under section 3.6(1), including by making interim payments if the full entitlement has not yet been determined.'

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 amount and duration of financial support, with consideration of dispute information.

Table 4.2.3: Detailed assessment by KPI of the implementation of Scheme sub-objective b.2

KPI TITLE	DESCRIPTION	RAG	ANALYSIS	RECOMMENDATIONS
AVERAGE BENEFIT PAYMENTS	Average benefit payment per claimant by injury severity level.		The latest schedule 1E parameters as at 15 January 2021 indicate that the average claim size of: • At-fault claims is expected to be $16,800 • Not-at-fault minor injury claims is expected to be $5,700 • Not-at-fault non-minor injury claims with Whole Person Impairment (WPI) less than or equal to 10% is expected to be $131,100 • Not-at-fault non-minor injury claims with Whole Person Impairment (WPI) greater than 10% is expected to be $520,600 For at-fault claims and not-at-fault minor injury claims, the actual average claim size is broadly in line with what was expected in the 2018-2020 accident years to date. Actual experience is credible for these types of claims which have a shorter duration of benefits and this is reflected in the schedule 1E parameters. For non-minor injuries, considering common law damages milestones taking longer to reach, the actual experience is not yet credible enough to be able to make an assessment on the reasonableness of the schedule 1E parameters. While the above information is useful and interesting, there are several underlying benefit components within the 1E parameters that are aggregated up to yield these figures, including weekly, medical, and other benefits. It is difficult to assess the adequacy of these average benefit payments without analysing further granular details. As a result, we view an independent claim file review would be best suited to assess the reasonableness of ongoing financial support provided to claimants in the form of financial and non-financial benefits. For weekly benefits, the benefit amount is linked with Pre-Accident Weekly Earnings (PAWE). Several submissions highlighted complexities in this process and the data provided highlights this is a key area of dispute. There are also reports this is similarly the case for medical benefits payable. We have considered individual benefits categories including weekly benefits and treatment and care in the next KPI.	We support Recommendation 14 in Clayton Utz's analysis that 'SIRA should undertake a review of the weekly payments framework, to assess what steps can be taken to enable a greater proportion of earners to receive their full entitlement sooner and to minimise disputes.'
BENEFIT DURATIONS	Proportion of claimants who have had their injury assessed and are receiving benefits at specific durations post injury.		For all accidents from Scheme inception to 31 December 2020 across all insurers, the following table shows: a) the percentage of claims eligible for weekly benefits that have been assessed and have been paid weekly benefits as at the 13th, 26th and 52nd week post injury	**Recommendation 15:** The metrics and analysis reveal benefits are generally being paid consistent with legislative requirements, which provides for more benefits to be paid to more severely injured claimants.

b) the percentage of claims that have been assessed and have been paid treatment are care benefits post 26 weeks after the injury *(Qlik, Statutory benefit details 4 of 6 & Statutory benefit details 6 of 6)*

Claimant Category	Weekly benefits paid as at week:			Treatment and Care benefits paid post 26 weeks
	13	26	52	
Non-Minor NAF >10%	54.7%	50.6%	44.8%	89.7%
Non-Minor NAF <=10%	45.0%	37.2%	32.2%	87.0%
Minor NAF	9.6%	3.2%	0.5%	25.4%
At-fault or Mostly at-fault	26.2%	9.7%	0.2%	22.9%

Some key notes on the statistics above:

- The denominator for a) only includes claims that have reached the 13/26/52 week milestone, and therefore these percentages are not deflated by claims that have not yet reached that point in time.
- Mostly at fault includes those with greater than 61% contributory negligence according to Division 3.3 Section 3.11 of the MAIA (Act).
- Claims with fault status 'undetermined' have been included in this analysis as a large proportion have historically been assessed as not at-fault claims in line with the Scheme Actuarial monitoring reports. These claims represent a minority proportion of total claims.

We did not observe a material difference by insurer for each of the following claim benefit durations. However, we did observe that some

The metrics consider claimants that are on benefits. We recommend monitoring of the proportion of claimants **that have not recovered or been able to return to work** (not just those on benefits) from their injury and have not been paid benefits within each of the categories considered. We would expect this proportion to be small, except perhaps for minor and at-fault / mostly at-fault claims where benefits entitlements are limited, however it is for this proportion of claims that are potentially not receiving ongoing financial support that may be in need.

Whilst our analysis does not consider the appropriateness of the duration of benefit payments in regard to the legislations, we support Recommendation 37 and Recommendation 40 of Clayton Utz's analysis which recommends changes to the duration of benefit payments for persons with minor injuries and those that were wholly or mostly at-fault.

insurers did not have any claimants on benefit for some claimant category / duration combinations, and it is difficult to know whether this is accurate or a data error. We recommend the data underlying the metrics in the above table, which was extracted from Qlik, is reviewed for accuracy.

Non-minor not-at-fault injury claims are eligible for weekly benefits for at least 2 years (104 weeks). Further, the legislation excludes the following cohorts of claimants from receiving benefits post 26 weeks after the injury:

- Weekly benefits - Claimants with minor injuries or if at fault or mostly at fault
- Treatment and care benefits - Claimants with minor injuries or if at fault or mostly at fault and the person was over 17 years of age at the time of accident. However, benefits can be payable in respect of minor injuries as per 5.16 of the Motor Accident Guidelines.

Therefore, we expected a materially higher number of Non-minor not-at-fault injury claimants would be on benefit compared to Minor and At-fault claimants as observed in the above table.

We also expected, and observed, a reduction in the proportion of claimants on benefit at longer durations consistent with some claimants recovering to the extent they are fit to return to work.

The proportion of at-fault or mostly at-fault claims receiving weekly benefits as at week 13 appears (26.2%) to approximately half way between Non-Minor NAF (45.0%) and Minor claims (9.6%), which appears reasonable given at-fault or mostly at-fault claims could be minor or non-minor.

A small proportion of minor and at-fault or mostly at-fault claims remain on weekly benefits at 52 weeks post the injury, which is not required to be paid under the legislation. Similarly, 22.9% of claims where the injured person was at-fault or mostly at-fault received treatment and care benefits post-26 weeks. This is also not required under the legislation however we understand through stakeholder discussions this is being done consciously to provide ongoing treatment and care support for injured persons in need of these benefits.

25.4% of claims with injuries classified as minor had treatment and care benefits post 26 weeks. This is in line with the legislation and indicates

			claimants with minor injuries are provided ongoing treatment and care support.	
COMPLIMENTS, COMPLAINTS, INTERNAL REVIEWS AND DISPUTES	Volume and proportion of compliments complaints, internal reviews and disputes and key reasons for these.		178 compliments and 635 complaints were received considering data from 1 April 2020 to 31 March 2021 *(CTP Insurer Claims and Experience and Customer Feedback Comparison March 2021)*. The largest category of these complaints (45%) was in respect of 'claims management', and together with 'claims decisions', 'delays' and 'service', comprise 90% of complaints. There was insufficient data to make conclusions about compliments or complaints in respect of ongoing financial support. There are three types of internal reviews which are discussed in detail in Objectives (d) and (g). If the customer continues to disagree with the insurer about their claim after the insurer internal review, customers may apply to the Personal Injury Commission for an independent determination of the dispute. The Personal Injury Commission was established on 1 March 2021 as a new tribunal that handles both motor accident and workers compensation disputes in NSW. Prior to this, SIRA managed motor accident dispute resolution functions through its Disputes Resolution Service (DRS). Considering data from 1 December 2017 to 28 February 2021, 7,169 disputes were received according to the Quarterly CTP Insurer Claims and Experience and Customer Feedback Comparison March 2021 report. Of these disputes, 2,854 or 40% have been determined, with the following key results: • Overall, 41% of insurer decisions are overturned and 55% are upheld. • In respect of weekly benefit payment amounts, 55% of insurer decisions are overturned and 45% are upheld. • In respect of treatment and care benefits, 46% of insurer decisions are overturned and 54% are upheld. • In respect of whether the injured party is mostly at fault, 64% of insurer decisions are overturned and 36% are upheld. While the proportion of claimants that dispute their claim is approximately 20% i.e. the majority or 80% do not dispute their claim, it is concerning that 41% of insurer decisions are overturned. The independent claim file review found that for most claims (most of which are not disputed) treatment and care benefits are appropriate. It would	**Recommendation 16:** Given 41% of insurer decisions are overturned, we recommend an independent claim file review consider whether claimants were provided adequate ongoing financial support for their particular needs and circumstances, focussing on claims that were not disputed at the DRS, however displayed similar characteristics to those that were overturned in favour of the claimant at the DRS to further glean insights into the appropriateness of internal reviews. We are in support of Recommendation 26 and 27 of Clayton Utz's analysis which recommends the setting of maximum acceptable overturn rates in relation to statutory benefits decisions that are the subject of merit review, medical assessment and miscellaneous claims assessment under the Act on referral by the claimant.

		be useful to consider whether these claimants were provided adequate ongoing financial support for their particular needs and circumstances. It is noted that overturn rates do not include withdrawn claims. There are circumstances where claims are withdrawn by claimants following a change by the insurer to the decision under dispute, and this is not reflected in the overturn rates.

4.3 Objective (c): Compulsory CTP insurance

Table 4.3.1: Overall assessment of the implementation of Scheme objective (c)

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.

Overall, we view the Scheme is meeting its objective (c) since the CTP Scheme continues to be mandatory for all NSW vehicle owners.

Objective	Overall RAG
(c) is to continue to make third-party bodily insurance compulsory for all owners of motor vehicles registered in New South Wales.	

Suggestion 17: Consistent with the ICA submission, we suggest monitoring of:

- the detection rate of non-compliance with registration and insurance requirements
- the annual number of breaches of the requirements for registration and insurance detected and actioned by NSW Police.

These measures will provide insights into both detection and compliance behaviour and may offer additional value when considered in concert with measures relating to affordability (such as utilisation of short-term registration).

Suggestion 18: Consistent with the ICA submission, we suggest monitoring of:

- the utilisation of the nominal defendant Scheme
- measure of the number of claims received under the uninsured nominal defendant provision (to be used with the previous suggestion in objective (c)).

4.4 Objective (d): Affordability

Table 4.4.1: Overall assessment of the implementation of Scheme objective (d)

Objective	Overall RAG
(d) is 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	
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	
d.2: To keep premiums for third-party policies affordable by limiting benefits payable for minor injuries	

Overall, we view the Scheme is meeting its objective (d) overall:

- Overall, less than one week of household income is required to pay for the average NSW CTP premium, including for low income households. On comparison of the affordability of personal lines insurance policies, NSW CTP premiums are significantly more affordable.
- A larger proportion of the total premium payable including GST and levies goes towards claimants. On a prospective basis, the Schedule 1E parameters this has been fairly stable over the last 4 years with claims (48%), expenses (12%), profit margin (5%) and Levies and GST (35%). 17% of total premium is in respect to the Lifetime Care and Support Fund and is a part of the Levies and GST component.
- TEPL has not yet been enacted to manage profit margins due to the current maturity level of development of claims experience. However, per the schedule 1E premium parameters, insurers filed for pricing levels that included an 8% profit margin on premiums (excluding GST and levies). The REM has been enacted which assists in avoidance behaviour by insurers related to specific high-risk segments to ensure all people of NSW can buy cover at an affordable rate. If profit margins are above 10%, the TEPL mechanism may return any excess profits to policyholders and through stakeholder discussions we understand activation of the TEPL mechanism may be considered at the next review. As TEPL has not been activated in the three-year review period, and considering the risks highlighted above, we have not been able to assess implementation of it and therefore rated this component as 'Amber'.

We make the following recommendations to assist in continuing to meet objective (d), while balancing other objectives:

- **Recommendation 19:** CTP insurance is a product that provides benefits to society though sold for profit, and the ideal outcome is that all participants act with integrity to assist balancing those objectives. There is at least a perception through some stakeholder discussions and feedback amongst claimant representatives that the balance of power lies with the insurers on disputed matters. It is recommended that insurers continue to develop cultures where policyholders are treated fairly and compassionately.
- **Recommendation 20:** Given the relatively higher level of affordability of NSW CTP premiums, there is the potential that some premium increases may be absorbed by policyholders whilst still meeting the affordability objective. We recommend any review of premiums balances the Scheme objectives, including affordability, to encourage early and appropriate treatment and care, financial support for injured persons, to achieve optimum recovery of persons from injuries sustained in motor accidents, and to maximise their return to work or other activities.

- **Recommendation 21:** Conduct another review into the reasons for markedly lower claims frequency in the Scheme compared to the original Schedule 1E parameters. For example, whether there is different experience observed in data from hospitals across different geographical locations, which may help create a link to claim reporting patterns for vulnerable people such as those who require an interpreter or other assistance. Further we recommend that SIRA make it a requirement that insurers accurately record for each claim the 'Interpreter Required' field, which may be used to support this analysis.
- **Recommendation 22:** We recommend that SIRA maintains its discretion to trigger the TEPL mechanism, with due reference to advice from the scheme Actuary and Premium Committee. We are supportive of comments made by SIRA's chief executive at the Law and Justice Committee hearings that activation of the TEPL mechanism will be conducted at interim annual reviews once desired confidence levels are achieved.

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 insurer profit 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.

Table 4.4.2: Detailed assessment by KPI of the implementation of Scheme sub-objective d.1

KPI TITLE	DESCRIPTION	RAG	ANALYSIS	RECOMMENDATIONS
PREMIUM AFFORDABILITY	Ratio of premium to the AWE.		**Overall, less than one week of household income is required to pay for the average NSW CTP premium. On comparison of the affordability of personal lines insurance policies, NSW CTP premiums are significantly more affordable.** Household income is a critical consideration in understanding affordability pressures. The average number of weeks of household income needed to pay for insurance is a more frequently used metric in recent years that can be used to assess this. The average annual cost of NSW CTP insurance over the last three years has been less than $450 per annum according to premium data provided by SIRA and publicly available registered vehicle data by Transport NSW. The average NSW Average Weekly Earnings (AWE) over the same period has been approximately $1700 per week according to the Australian Bureau of Statistics (ABS). This indicates the average NSW CTP insurance premium can be paid from household income in under one week on average across NSW. By comparison, affordability of other personal lines insurance policies such as home insurance, the ability to pay a home insurance premium within 2 weeks is considered to indicate there is no affordability pressure, and only low affordability pressure if the ability to pay a home	**Recommendation 20:** Given the relatively higher level of affordability of NSW CTP premiums, there is the potential that some premium increases may be absorbed by policyholders whilst still meeting the affordability objective. We recommend any review of premiums balances the Scheme objectives, including affordability, to encourage early and appropriate treatment and care, financial support for injured persons, to achieve optimum recovery of persons from injuries sustained in motor accidents, and to maximise their return to work or other activities.

			insurance premium takes 2-4 weeks. Given the average NSW CTP premium can be paid within 1 week, we view therefore that NSW CTP premium levels are affordable. Using AWE has its limitations as it does not account for other sources of income such as retirement and investment income and does not give an accurate reflection of underlying disposable income. However, we view that for the purpose of this analysis, given the low proportion of household income required to pay for NSW CTP premiums, AWE provides a sufficient measure. **The ABS 2017-2018 Survey of Income and Housing considered low income earners as a segment. For all categories of income earners, there does not appear to be any affordability pressures on average for each category.** • The average income of low-income households was $433 per week in 2017–18. Ignoring inflation of earnings to 2021 values, the average NSW CTP premium could be paid in 1 working week. • The average income of middle-income households was $902 per week in 2017–18. Ignoring inflation of earnings to 2021 values, the average NSW CTP premium could be paid in 2.5 working days. • The average income of high-income households was $2,142 per week in 2017–18. Ignoring inflation of earnings to 2021 values, the average NSW CTP premium could be paid in 1 working days. We considered whether the above analysis could be conducted at a location or local government area (LGA) level as there is a more complex interaction of income, location, and other factors, which impact premiums and affordability. However, given the results revealed a high level of affordability for low income earners, we did not pursue this as we did not view it would provide additional insight.	
PREMIUM MAKEUP	Claims and expenses as a percentage of premium by insurer since 2017 Scheme inception.		Based on Schedule 1E parameters as at 15 Jan 2021 and prior years, the makeup of the total premium payable including GST and levies, has been fairly stable over the last 4 years with claims (48%), expenses (12%), profit margin (5%) and Levies and GST (35%). 17% of total premium is in respect to the Lifetime Care and Support Fund and is a part of the Levies and GST component. A larger proportion of premium goes towards claimants on this prospective basis. Note that the basis for the profit margin calculated above is different to the filed profit margin	**Recommendation 21:** Conduct another review into the reasons for lower claims frequency in the Scheme compared to the original Schedule 1E parameters. For example, whether there is different experience observed in data from hospitals across different geographical locations,

of 8% which is calculated as a proportion of premiums excluding GST and levies.

According to data provided by SIRA, total premiums collected in the 2018 accident period (including Dec17) were $3,241m. Under the Scheme Actuary valuation as at 31 December 2020, $1,505m is ultimately expected to be paid in claims indicating a 46.4% loss ratio. Similarly, the expected ultimate loss ratios for the 2019 and 2020 accident years are 51.4% ($1,478m out of $2,877m) and 51.6% ($1,475m out of $2,860m). These are broadly consistent with the overall claims' component of the Schedule 1E parameters. This is not surprising given the Scheme Actuary uses the valuation as input to the Schedule 1E parameters, however our observation is that the actual average claim frequency and claim size assumptions adopted by the Scheme Actuary are broadly consistent with the experience to date (with the exception of not-at-fault minor claims which are significantly under-developed).

We observed that claim frequency has reduced in each accident year since 2018 consistently across all claim types including at-fault and not-at-fault, minor and non-minor claims. Claims frequency is 20% lower than the original 1 December 2017 Schedule 1E total claims frequency parameter. Average claim sizes have also been lower than the original 1 December 2017 Schedule 1E parameters.

A report from Ernst and Young titled 'Analysis of Propensity to Claim Trends MACA to MAIA' in August 2020 found that overall propensity to claim (measured as the proportion of reported claims to casualties) has reduced overall in the MAIA 2017 Scheme compared to the MACA 1999 Scheme, however it has increased for Non-minor claims and reduced for Minor claims. The reduction in Minor claims propensity is driven by a reduction in Severity 1 Whiplash claims. The increase in non-Minor claims is analysed considering factors that may be driving these results including Claimant Age, Location and relevant Socio-Economic Disadvantage, and the presence of psychological injuries. The report concluded that interpreter data as specified by the field 'Interpreter Required' is not of a standard required to draw conclusions from, with some insurers not providing this field.

There were submissions that suggest claim frequency is lower than expected because of less awareness of scheme entitlements and difficulty in navigating a compensation system where there is limited legal involvement and limited financial incentive for lawyers to be involved. One paper indicates that the claim frequency for those that require an interpreter has reduced by 70%-80%. There appears to be a

which may help create a link to claim reporting patterns for vulnerable people such as those who require an interpreter or other assistance. Further we recommend that SIRA make it a requirement that insurers accurately record for each claim the 'Interpreter Required' field, which may be used to support this analysis.

			dis-proportionate reduction in claim frequency for those under the age of 20. There has also been a significant reduction in claims against the nominal defendant. It is not clear whether there has been an unintended adverse impact on lower socio-economic groups and other disadvantaged cohorts that may legitimately be entitled to claim benefits. Based on information provided by SIRA officers: • approximately 40% of inbound enquiries related to seeking information on how to lodge a CTP claim. Since September 2020, SIRA has been measuring the effectiveness of milestone calls that are not related to damages claims. From 12,952 attempts, a total of 3,704 successful calls were recorded. • All CTP Assist services can be provided through an interpreter or translated from English into a community language. • SIRA has also developed a 12-part CTP animation series which has been translated into Arabic, Cantonese, Mandarin, Korean, Vietnamese and Greek to make them more accessible to the community. From an actuarial perspective, overall, the changes in assumptions do not appear unreasonable, however we note the uncertainty given the lack of experience for damages claims. As at 31 December 2020, 24% of the ultimate expected payments for first year have been paid. The vast majority of the remaining 76% relate to lump sum damages payments. These figures are 16% and 7% for the 2019 and 2020 accident years.	
PROFIT MARGINS AND MECHANISMS	Insurer profit margins on the average premium since 2017 Scheme inception and mechanisms to manage profit margins.		TEPL has not yet been enacted to manage profit margins due to the current maturity level of development of claims experience. However, per the schedule 1E premium parameters, insurers filed for pricing levels that included an 8% profit margin on premiums (excluding GST and levies). The REM has been enacted which assists in avoidance behaviour by insurers related to specific high-risk segments to ensure all people of NSW can buy cover at an affordable rate. Only 24% of ultimate expected payments have been made for the first accident year (2018) according to the Scheme Actuary's 31 December 2020 report. This figure is 16% for the 2019 accident year, and 7% for the 2020 accident year. Given it will take several years before 95% of payments are made in a given accident year, we understand SIRA considered whether it could be statistically 90% confident that when the 2018 accident year reaches 95% of payments, the profit margin would be within the required 3-10% bounds. We understand a 90% confidence	**Recommendation 22:** We recommend that SIRA maintains its discretion to trigger the TEPL mechanism, with due reference to advice from the scheme Actuary and Premium Committee. We are supportive of comments made by SIRA's chief executive at the Law and Justice Committee hearings that activation of the TEPL mechanism will be conducted at interim annual reviews once desired confidence levels are achieved.

level has not been reached yet, however that there is an 86% chance of profit margins being in excess of 10%, and we also understand some insurers have set aside reserves in preparation for the activation of the TEPL.

On the other hand, the REM has been successfully implemented per a 29 September 2020 paper in respect of policies effective 15 January 2021, based on analysis completed by Ernst and Young, on NSW CTP claims data to 30 June 2020. The REM appears to have been managed using appropriate judgement taking account of the maturity of the scheme and the potential for claims to materially develop further and a range of uncertainties including uncertainty in the number and mix of vehicles and investment returns in the current COVID-19 environment.

Specifically, we understand that from the 2018 and 2019 accident years there was an aggregate deficit driven in part by greater growth than expected in South West Sydney. In 2020 per the Schedule 1E parameters, insurers collected $1 per policy to fund this deficit. We also understand that the net REM balance as at 31 December 2021 is in surplus and that SIRA proposes to hold off the distribution of any expected REM surplus in order to provide some buffer against unexpected changes that may result in a REM deficit e.g. uncertainty in the number and mix of vehicles and investment returns in the current COVID-19 environment. We understand this position is intended to be revisited if economic conditions stabilise or improve faster than expected. We consider this element to be 'green'.

If profit margins are above 10%, the TEPL mechanism may return any excess profits to policyholders and through stakeholder discussions we understand activation of the TEPL mechanism may be considered at the next review. A balance needs to be achieved in terms of the timing of activation of the TEPL mechanism, balancing the level of confidence of achieving expected profit levels, with minimising inter-generational inequity with the possibility that existing claimants did not receive benefits to the level originally intended by the Scheme, which may be a driver of excess profits, to the benefit of future policyholders and claimants.

As TEPL could not be implemented in the three-year review period, and considering the risks highlighted above, we have not been able to assess implementation of it and therefore rated this component as 'Amber'.

Background

		Transitional Excess Profits and Loss (TEPL) and Risk Equalisation Mechanism (REM) are two mechanisms that aim to ensure that insurers do not make excessive or insufficient profits, and reduce self-selection and risk avoidance behaviour by insurers, respectively. TEPL: • If profit margins are above 10%, the TEPL mechanism may return excess profit to policyholders. Conversely, if profit margins are below 3%, the TEPL mechanism involves a process of increasing future premiums to enable insurers to yield a 3% minimum profit margin. The TEPL mechanism is triggered based on industry profit margins rather than individual insurer margins, therefore even if TEPL is fully deployed some insurers may retain a profit margin outside the 3-10% range. • TEPL Guidelines refers that once SIRA is satisfied that 95% of payments have been made for a given accident year, the TEPL mechanism can be enacted. REM: • The main purpose of the REM includes reduction of self-selection and risk avoidance behaviour by insurers related to specific high risk segments and redistributing designated high-risk premiums equally through a back-office clearing house. The segments include Owner Age (17-22, 23-26, 27-54 & business use, 55+), vehicle age (0,1-4,5-12,13+), and Postcode relativity band for example allowing for differences in Metro compared to Country regions. • SIRA regularly reviews the REM amounts and recommends corrective actions to efficiently manage any surplus or deficit. This ensures that the REM does not advantage or disadvantage any insurer or unintentionally distort the market.

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.

[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

3. Increase in fraudulent claims.

Sub-objective d.2 addresses the first two (2) factors listed above and the third factor is addressed 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 was considered.

Table 4.4.3: Detailed assessment by KPI of the implementation of Scheme sub-objective d.2

KPI TITLE	DESCRIPTION	RAG	ANALYSIS	RECOMMENDATIONS
MINOR INJURY CLAIM BENEFITS	Proportion of premium paid to claimants with minor injuries compared to non-minor injuries.		There has been a total of $9.0b in premiums collected in the 2018-2020 accident years as advised by SIRA. For minor not at-fault claims, there is an estimated total ultimate cost of $93.7m, with $83.9m having been paid to 31 December 2020 according to the latest TEPL Report by the Scheme Actuary. This indicates that 1.0% of premiums collected in the 2018-2020 accident periods are expected to be paid to minor injury not-at-fault claimants. This proportion is similar by accident year: 0.9% in 2018, 1.1% in 2019 and 1.1% in 2020. This indicates that the majority of premium is being utilised for claimants with non-minor not at-fault injuries and is therefore meeting the Scheme objective. It is noted that there may be at-fault claims with minor injuries that are not included in the figures above. Regardless of minor or non-minor injury nature, at-fault claims have a similar benefit structure except that some benefits are reduced by their contributory negligence. 1.1% of premiums collected in the 2018-2020 accident period were paid to at-fault claimants.	N/A
MINOR INJURY CLAIM DURATIONS	Percentage of claimants with minor injuries that finish treatment and care claims within 6 months.		SIRA completed a review of the definition of minor injury against the objectives of MAIA 2017 in February 2020. The review found that 42% of people with minor injuries finished their treatment and care claims within 13 weeks after a motor accident, which increased to 75% by 26 weeks and 98% by 52 weeks. For claims finalised by 31 March 2021 that had health services and which occurred in accident years 2018-2020, 46.1% of people with minor injuries finished with health services within 13 weeks after the motor	

		accident, which increased to 83.3% by 26 weeks and 97.9% by 52 weeks *(Qlik, Time duration measures 2 of 3)*. For minor claims that have had weekly payments and occurred in accident years 2018-2020, 10.1% were receiving weekly benefits at 13 weeks after the accident, decreasing to 3.2% by 26 weeks and 0.4% by 52 weeks *(Qlik, Statutory benefit details 4 of 6)*.	
MINOR INJURY CLAIM LEGAL COSTS	Percentage of legal costs to the total claims costs and dispute costs associated with minor injury claims.	Legal and investigation costs represent 11.3% of minor injury claim payments *(Qlik, Legal claims and costs & Payments overview 1 of 2)*. This is a material amount for injuries that would mostly be expected to cease receiving benefits within 26 weeks. Note also that the 31 December 2020 Scheme Actuary report states that there are on average 200 claims per quarter (approximately 13%) transitioning out of the not at-fault minor injury claim type into other claim types. There were 3766 determined insurer internal reviews (IIRs) regarding minor injury of which 460 reviews (12.2%) were overturned in favour of the claimant. Here, IIRs regarding minor injury comprise 35.5% of total determined IIRs *(Qlik, Insurer internal review (IRR) 3 of 5)*. 55.0% of finalised IIRs (which includes determined, declined, withdrawn and no decision internal reviews) were referred to DRS for minor injuries. Here, it is also noted that a claim can have multiple IIRs and multiple DRS disputes. For the purpose of measuring the conversion rate from finalised IIR to DRS, the DRS disputes and the IIRs have been grouped into the high-level dispute areas separately so there may not be one to one mapping between them *(Qlik, IRR and DRS 1 of 2)*.	**Recommendation 23:** Minor injury assessments are completed until up to around three months after being reported which can result in reclassification of claims. Given also that 55% of internal reviews were referred to the DRS (now PIC) and the operational and legal costs incurred for these claims, we recommend an independent claim file review is conducted to understand the drivers of minor injury claim disputes and the associated cost of these.

4.5 Objective (e): Premium setting and SIRA's role

Table 4.5.1: Overall assessment of the implementation of Scheme objective (e)

Objective	Overall RAG
(e) is 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	
e.1 To promote competition in the setting of premiums for third-party policies	
e.2: To promote innovation in the setting of premiums for third-party policies	
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	

Overall, we view the Scheme is meeting its objective (e) given:

- the entrance of a new insurer into the Scheme, Youi.
- opportunities for innovation being created, with the option for insurers to create their own innovations and potentially be rewarded for them.
- the Scheme appears to be sustainable for Policyholders, Claimants, Insurers, and the Government.

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.

Table 4.5.2: Detailed assessment by KPI of the implementation of Scheme sub-objective e.1

KPI TITLE	DESCRIPTION	RAG	ANALYSIS	RECOMMENDATIONS
CHANGES IN MARKET SHARE	Percentage change in market share year on year for each insurer.		Since commencement of the Scheme in December 2017 to June 2020, premium market share has decreased for NRMA by 0.6% and the Suncorp brands AAMI and GIO by 2%, offset by increases for QBE (1.5%) and Allianz	N/A

			(1.1%) according to the 2020 CTP scheme performance report. These are changes are not immaterial variations for these insurers when considered as a proportion of total premium income. Changes in market share are an indicator of competitiveness in the insurance market, and therefore these movements provide a positive view of competition. This is despite the MAIA Scheme including the REM which equalises the benefit of writing better risks for certain risk factors including age of policyholder, age of vehicle and vehicle location. To an extent the REM does not promote competition, however, assists in meeting other Scheme objectives including affordability and sustainability.	
MARKET PLAYERS	Retention of licensed insurers and addition of new entrants.		Since MAIA scheme inception, all insurers have continued to underwrite CTP personal injury insurance cover. It is noted that one of the Allianz entities 'CIC Allianz' ceased to sell CTP policies from 15 January 2019, however Allianz still offers CTP insurance through a separate entity. Youi has entered the NSW CTP market effective 1 December 2020. Retention of existing insurers and addition of new insurers such as Youi indicates the market appears to be competitive. A stakeholder submission by an insurer has stated that the current premium filing process is lengthy and complex. Furthermore, interim premium filing processes, which permit premium adjustments within a 4% range of the current premium was regarded as similar to the full premium filing process in terms of process and timeframes.	**Recommendation 24:** We recommend that consideration be put forth to simplify both the full and interim premium filing process in the Motor Accident Guidelines. This can encourage competition amongst the market by increasing price competition amongst existing insurers and providing potential new entrants with less administrative burden.

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.

Table 4.5.3: Detailed assessment by KPI of the implementation of Scheme sub-objective e.2

KPI TITLE	DESCRIPTION	RAG	ANALYSIS	RECOMMENDATIONS
OPPORTUNITY FOR INNOVATION	Opportunities created for innovation.		Since Scheme inception some opportunities for innovation have been created. This includes innovation in respect of CTP insurance for point-to-point (P2P) transport vehicles, and policy wordings that reflect vehicle usage. These innovations reflect changes to the real-world and environment we live in. For example, family cars can be used for everyday commuting, provide fare paying passenger services or even delivery services. This has forced the industry to consider what functions vehicles are performing at any one point in time. An example of an opportunity for innovation that has been created is explored below. In our view, given the relatively early maturity level of the Scheme, the fact that some innovations are being explored indicates that the Scheme is meeting its objective of promoting innovation in the setting of premiums for third-party policies. SIRA in its consultation paper 'CTP for taxis and hire vehicles in the point to point industry' dated February 2021, is consulting on a proposed principles-based / equitable pricing of premiums for the P2P industry (taxis, ride-share, hire car etc under 12 seaters) through tailored agreements that more accurately reflect the risk solution that could replace how P2P premiums are currently determined and paid. We understand this is targeted to be in place by 1 December 2021. The proposed solution enables insurers and the P2P industry to negotiate how premiums are paid including allowing another party to pay part of the premium on behalf of the policy holder after the CTP policy is issued. Insurers would use digital information or quantitative data to differentiate risks to the scheme. Some solutions being considered are: • an initial premium combined with subsequent refunds; • premium instalments based on fare-paying kms travelled, telematics data on vehicle usage safety, location, time of day use, driver condition, vehicle usage and safety features; or • applying a discount or loading to premiums depending on a risk assessment of the policyholder and vehicle. It is proposed that it would be mandatory for insurers to offer innovative P2P premium rating to medium to large service providers (those who reasonably expect to carry out 100,000 or more paid fare trips annually), recognising that it may not be cost-effective for insurers to negotiate significant numbers of individual agreements with small service providers. Furthermore, an insurer may refuse to provide access to an alternate premium determination method if they are not satisfied with the quality of data provided by an authorised service provider.	N/A

RECOGNITION OF INNOVATION	Recognition of innovation opportunities created.		Under the 'Motor Accident Guidelines - Transitional excess profits and transitional excess losses', SIRA may take into account innovations implemented by insurers to promote the objects of the Act in adjustment of the fund levies of premiums for the purposes of TEPL provisions. SIRA has advised that there have been nine innovation applications formally submitted to SIRA since the inception of the 2017 scheme. One application has received preliminary approval, one was rejected, and other applications are being processed. It is apparent that there are mechanisms in place to create opportunities for innovation and that these are starting to be recognised. However, it is our view that it is too early to assess the effectiveness of recognition of innovation opportunities. We are supportive of Recommendation 21 in Clayton Utz's analysis that 'SIRA undertake a consultation to report on any barriers in the Scheme to innovation in the setting of premiums and other aspects of the conduct of CTP insurance business, and the extent and manner in which removal of those barriers would affect: (a) affordability; and (b) the flexibility and incentive for insurers to innovate in ways that advance the objectives of the Act and encourage safer driving decisions.'	N/A

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.

Overall, we view that the Scheme is meeting this sub-objective, as the Scheme appears to be sustainable for Policyholders, Claimants, Insurers, and the Government:

- Sustainable for Policyholders:
  - The average premium based on Schedule 1E parameters reduced from $526 at 1 December 2017 to $503 at 15 January 2021, a 4.4% reduction. The average premium has remained steady at approximately $500 for the last 3 years.
  - Less than one week of household income is required to pay for the average NSW CTP premium, including for low income households. On comparison of the affordability of personal lines insurance policies, NSW CTP premiums are significantly more affordable.

- Sustainable for Claimants:

- Benefits payable directly to claimants account for 48% of the total premium payable (including GST and levies); this increases to 73% when GST and levies are excluded. Based on the Scheme Actuary valuation as at 31 December 2020, the claims ratios for each of the first three accident years were 46.4% in 2018, and 51.4% and 51.6% in 2019 and 2020 respectively, based on premiums including GST and levies.
- Approximately 80% of claims have not been the subject of a dispute. While there remains room for improvement, the proportion is sufficiently high that it appears sustainable for Policyholders and Claimants.
- Similarly, there has been high customer satisfaction based on Net Promotor Score (NPS) and Customer Experience Score (CES) results. The rolling 4-month average Voice NPSs were 43, 53 and 67 over 2018-2020 respectively. According to the Australian NPS Pulse Check, CTP Assist is as at June 2020 a national leader in delivering a great customer experience. There has been a positive trend in the NPS scores over time and there is a large proportion of promoters in comparison to detractors. Also, the Customer Effort Score (CES) measures how easy it is for a customer to get the help they need. The score is out of 5. The Voice Customer Effort Scores (CES) were 4, 4.1 and 4.4 for 2018-2020 respectively. The CES also has a positive trend and has maintained high scores over time.
- Claimants have access to statutory and/or common law benefits, and this is dependent on a number of factors but most importantly the severity of injury.
- A downside to the current Scheme operation is access to adequate support or awareness of that support for some complex claims. This is an area for improvement, however on weight of the other aspects considered above, we view the Scheme is sustainable.

- Sustainable for Insurers:
  - On an expected basis, insurer profit margins have been filed each year since Scheme inception at 8% of premiums excluding GST and levies.
  - On an actual basis, given only 24% of payments have been made for the 2018 accident year it is significantly under-developed in light of common law damages claim settlement amounts yet to be determined, and too early to know what the actual profit margin will be. Initial analysis indicates it is likely that at least an 8% profit margin will be achieved for the 2018 accident year across the Scheme.

- Sustainable for the Government:
  - A well and fair functioning insurance market is in place to cover motor vehicle accident injuries.
  - A new entrant, Youi, has entered the market indicating that the barriers to entry are not too high. The market is functioning reasonably well in light of policyholders, claimants and insurers achieving outcomes that are fair and sustainable for each of them as outlined above.
  - Overall, claimants have access to early and appropriate treatment and care as discussed in objective (a), and the proportion of claimants lodging disputes is 20%, i.e. 80% of claimants do not dispute their claim. The existence of avenues for dispute improves the sustainability of the Scheme, although there is room for improvement in respect of dispute resolution processes.

4.6 Objective (f): Deter Fraud

Table 4.6.1: Overall assessment of the implementation of Scheme objective (f)

Objective	Overall RAG
(f) is to deter fraud in connection with compulsory third-party insurance.	

Overall, we view the Scheme is not meeting its objective (f).

There is a lack of overall fraud detection and prosecution in the Scheme and visibility of this. There does not appear to be any published decisions available regarding cases implementing the penalties and remedies available pursuant to MAIA 2017. These penalties and remedies are not being utilised, or at least visibly utilised, which may result in an increase in fraudulent or false and misleading claims.

There are many barriers that currently exist to identify and detect fraud under the CTP Scheme including the sharing of information between different Scheme participants. Further, there does not appear to be clear accountabilities, roles and responsibilities in respect of fraud deterrence.

We note also that SIRA is proactively seeking to enhance its fraud prevention and deterrence capabilities via a data analytics solution which Deloitte are supportive of to help enhance objective (f).

Recommendation 25: We recommend that SIRA engage with insurers and NSW Police to identify the most efficient way of accessing the information and data pertaining to potentially fraudulent claims, and to the extent it will be released to the claimant. For example, a portal system could be set up for release of all police investigations relating to a matter in which a CTP claim is made, once investigations are completed. This would avoid the need for making multiple Government Information (Public Access) Act 2009 (GIPA) applications which require authorisation by the parties and lead to highly relevant police outcomes, particularly with regard to suspected fraudulent claims, being available to insurers in the early stages of investigating a claim.

Recommendation 26: We recommend a thorough investigation into the extent and nature of fraud and potential fraud which will then form the basis of accountabilities, roles and responsibilities in respect of fraud deterrence across all Scheme participants.

Additional suggestions to monitor and deter fraud are included further below.

Potential sources of fraud

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

Soft fraud involving the exaggeration of injuries or losses is very difficult to investigate and prosecute. There can be a fine line between submitting a legitimate claim that places the claimant in the most favourable situation and an exaggeration that can tip the claim into the soft fraud category.

Single vehicle accidents without witnesses are another potential source of fraud, for example, instances where the claimant allegedly blacked out or claims there was an animal, gravel or ice on the road that lead to the crash. Reverse onus requires the insurer to prove the claim is fraudulent and is difficult in these cases.

The percentage of claims which were submitted for insurer internal reviews and subsequently withdrawn was 6% in 2020 in 8% in 2021. Around 10% of disputes provided to the DRS until 28 February 2021 were withdrawn. It is our experience that a subset of such withdrawn claims may have some fraudulent element, which led to withdrawal due to the requirements of satisfying the internal review or DRS process. Undetected fraud leads to increased claims costs, which are passed on to policyholders via higher future premiums. All endeavours to monitor and reduce fraud are encouraged.

Fraud deterrence should be viewed with both a preventative and detective lens. The visible penalties and prosecution of perpetrators of detected fraud may act as a deterrent. Preventative measures can include educating the public about fraud and limiting opportunities for the enactment of fraud.

Fraud reporting and monitoring

There is a lack of overall visibility of fraud detection and prosecution in the Scheme, which may result in more fraudulent activity. Monitoring and reporting on fraudulent activity in the scheme is currently fragmented across the many stakeholders in the Scheme that play a role in deterring fraud including SIRA, the insurers, the NSW Police Force (Taskforce Mercury and previously Strike Force Ravens), Transport for NSW, Service NSW, and the public. One of the barriers noted by SIRA is the insurers' inability to share information with other insurers and State and Commonwealth agencies, for example, Medicare and Centrelink or other health-related records.

Stakeholders have collaborated in some instances; however, there is no comprehensive view on the volume of investigations into fraud. Between June 2018 and December 2020, SIRA received 10 tip-offs regarding fraud of which 2 were referred to NSW Police Force and half were in respect of the 1999 Scheme. Although Taskforce Mercury and SIRA collaborate closely, there have been no prosecutions to date on the 2017 Scheme, and hence no recoveries. Taskforce Mercury has prosecuted claims from the 1999 Scheme.

Transport for NSW Centre for Road Safety maintains statistics on serious injuries, e.g. injuries that require hospital admission. They recorded 11,350 serious injuries in 2018, 11,085 in 2019 and 10,806 in 2020. More than half of these serious injuries are not matched with police reports. In 2018 and 2019, SIRA records 12-14% more CTP claims than serious injuries, which is not unexpected as not all CTP claims will require hospital admission. However, in 2020, SIRA recorded 4% less CTP claims than serious injuries requiring hospital admissions. More analysis needs to be performed to understand these differences and whether fraud is an element.

Suggestion 27: Monitor certain key metrics (detective), for example:

- 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. As described above, while this ratio is available at a high-level, the ratio for 2020 appears unusually low and more analysis is necessary.

Suggestion 28: Implement specific fraud deterrence initiatives (preventative), for example:

- Dissemination of monitoring insights to the public.
- Education around the criminality of exaggeration of injury or losses in insurance claims.

Suggestion 29: Monitor reasons for withdrawal of claims, applications for insurer internal reviews, and disputes with the PIC, for indications of fraudulent elements in claims.

4.7 Objective (g): Claim and dispute resolution

Table 4.7.1: Overall assessment of the implementation of Scheme objective (g)

Objective	Overall RAG
(g) to encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes.	
g.1: To encourage the early resolution of motor accident claims	
g.2: To encourage the quick resolution of disputes	
g.3: To encourage the cost-effective resolution of disputes	
g.4: To encourage the just resolution of disputes	

Conclusion

Overall, we view the Scheme has **room for improvement** to meet objective (g) for the following key reasons:

- The internal review process for the most part appears to achieve objective (g) particularly given the timeframes imposed. However, 50% of internal reviews progressed to the DRS during 2018-2020. 65% of disputes have been finalised by the DRS, and of the finalised disputes, 41% were overturned in favour of the claimant with 55% of insurer decisions upheld. In light of the significant proportion that progress to the DRS, we have included a recommendation that a review is conducted into the types of claims that are suitable for internal review compared to those that should proceed directly to the PIC including medical disputes relating to whole person impairment appears.

- There is room for simplification of key processes and decisions, particularly for certain types of claims. This includes assessment of PAWE and the limited requirements for verification of earnings which creates difficulty in continuing to monitor entitlements and at the same time 'deter fraud'. It also includes earning capacity decisions, relevant to the post-second entitlement period. To this end we have included a recommendation in respect of additional information that could be collected, and additional monitoring which may provide insights into the areas which can benefit from the greatest improvement.

- There are time limits set on claim lodgement, internal review related communications, and a number of other key processes, however, there does not appear to be any time limits on the PIC to resolve disputes. We understand from one submission that under the MACA Scheme there was a requirement for a decision to be made within 15 days of a hearing, and that this requirement has been removed. This extends, not only to decisions pertaining to statutory benefits, but to all certificates issued by the PIC, including medical assessment certificates. It was submitted that it is now frequently the experience of participants in the scheme that a Certificate is often issued three months after the actual date of assessment noted on the Certificate. In light of this experience, we have included a recommendation to set KPIs for the PIC including targets for resolution of disputes (potentially set differently allowing for

case type or complexity) within a certain time limit, and monitor the turnaround time (number of days) for the PIC to make a decision. It is noted that the PIC is not governed by the MAIA Act (2017), however it is an integral part of the Scheme. Thus, this recommendation would be appropriate for the Initial Review of the Rules of the PIC of NSW being undertaken from September 2021 to the first half of 2022.

- In light of higher levels of DRS expenditure in 2018-2020 compared to 2016-2017 under the MACA 1999 Scheme, we note there are opportunities to innovate the performance of PIC that should be embraced. There may be areas that require additional expenditure such as improvements to the portal system, and there may be areas of saving if it is unclear what benefit existing expenditure is providing. We recognise this is an operational matter for the PIC and not formally a part of this statutory review. Further we included a recommendation for more data to be collected and monitored to assess cost-effectiveness of the resolution of disputes as this was not made available for this review.

Stakeholder Analysis

There are several stakeholders that play an important part in the resolution of motor accident claims and disputes. We have considered some specific stakeholders below.

Claims managers: Insurer's claims managers play an important role in the resolution of motor accident claims. We were able to observe through the independent claim file review the outcomes of individual claims, however we could not observe the effectiveness of claims managers in resolving claims. We did not have access to information about the number of active claims each insurer's claims managers are typically responsible for at any one point in time ('caseloads'), where active indicates the claim is receiving regular payments. As a benchmark, in some personal injuries claims lines, we have observed claims manager caseloads are typically in the order of 100 active cases or less per full-time equivalent (FTE) claims manager when managed optimally in terms of being appropriately utilised so as not to create additional or wasted cost to insurers, and appropriately resolving claims. Caseloads may change dependant on whether there are catastrophes or other operational concerns which create short-term stretches on staff. Furthermore, we have observed that better practice management of caseloads includes triaging of claims based on the nature and severity of the claim, with specialist claims managers being utilised for more complex cases such as severe injuries or mental health claims. The more support required for the claim portfolio, the lower the optimal caseload for the claims manager, typically 30-50 active cases per FTE. Furthermore, we did not have enough budget or time to consider claim manager frameworks and practices, including onboarding, education, and training of claims managers, as part of this review.

Suggestion 30: We suggest that monitoring of average caseloads per claimant be formalised into reporting to understand the effect this may have on the resolution of claims. A balance should be targeted and incentivised with caseloads being set in a way that allows the resolution of claims, early and appropriately. This suggestion is viewed in complement to Recommendation 4 in Clayton Utz's analysis.

Internal review: There are three types of internal reviews: a Merit review (e.g. the amount of weekly benefits), a Medical assessment (e.g. permanent impairment, minor injury or treatment and care) and Miscellaneous claims assessment (e.g. whether the claimant was mostly at fault).

Insurers support internal review as they view it is easily accessible, quick, affordable and cost effective. Insurers also view that internal reviews are appropriate given an independent team from the original claims manager reviews the decision. We understand SIRA sets requirements for internal review processes and that SIRA completed quality assurance testing of the implementation of those internal review processes and requirements, including timeline and communication requirements with claimants.

Some plaintiff lawyers have submitted the internal review process for the most part appears to achieve the objective particularly given the timeframes imposed. However, there was a submission that medical disputes relating to whole person impairment (WPI) and medical treatment which impact such assessments, such as surgery, should not be determined by non-medically qualified internal reviewers.

It takes 23.1 days on average to reach a conclusion for internal disputes, which is in line with statutory limit requirement of 28 days. Although the average number of days to reach a resolution is 23.1 days, only 72% of internal reviews are completed within 28 days across the industry, with a range of 52-94% across individual insurers. This indicates that there are a range of matters being presented, some which are more complex than others that require differing amounts of time to resolve. It may also indicate differing and potentially less mature internal resolution processes for some insurers.

We recommend that a review is conducted into the types of claims that are suitable for internal review compared to those that should proceed directly to the PIC. Medical disputes relating to whole person impairment appears to be one example where disputes should proceed directly to the PIC. The decision on the types of claims that may be considered suitable or optional to the claimant should balance the different Scheme objectives. We support Clayton Utz who has made a formal recommendation in Recommendation 23 of their analysis that internal reviews do not apply a decision relating to the degree of permanent impairment of an injured person (including whether the degree of permanent impairment is greater than a particular percentage).

External Review (PIC, formerly DRS)

50% of finalised insurer internal reviews progressed to the DRS during 2018-2020. 65% of disputes have been finalised by the DRS, and of the finalised disputes, 41% were overturned in favour of the claimant with 55% of insurer decisions upheld.

Some submissions and stakeholder discussions indicated that given the complexities with paperwork and formality of the PIC, claimants have felt the need to get legal representation and support. We understand that legal costs for these disputes were intended to be confined by the Motor Accident Injuries Regulation 2017 ('the Regulations'), and limited to 16 monetary units (currently the equivalent of $1,660.16), however there are applications for additional costs outside what is permitted by the Regulations, where it is asserted that the matter involves 'exceptional circumstances' under s 8.10(4)(b).

We also understand through some stakeholder discussions that it is apparent a number of plaintiff law firms have not attempted to access additional costs and have incurred costs through the provision of their services without being compensated. The Law Society of NSW has stated that claimant lawyers do not receive a fee if a claim does not proceed past the internal review point, even where they have done a significant amount of work which has resulted in an insurer overturning the original decision. This lack of fee compensation has led to a number of claimant lawyers not being able to provide assistance to claimants until it has been referred to the PIC, leaving claimants without legal support until this stage of the claim dispute. The Law Society of NSW provide the view that claims can be resolved earlier in the claims process if some claimant lawyer costs associated with the earlier stages of the claims process are provisioned for in the legislation.

Suggestion 31: We suggest that monitoring is conducted on the number or proportion of applications for additional costs outside what is permitted by the Regulations (16 monetary units which is currently the equivalent of $1,660.16), where it is asserted that the matter involves 'exceptional circumstances' under s 8.10(4)(b), to gain insight into the nature of claims where this is most prevalent and therefore whether there are areas to improve in Scheme design and / or operation.

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.

As discussed in the analysis of objective (b), according to Section 6.19 of the Act and Section 4.35 of the Motor Accident Guidelines, an insurer must:

1. Give notice for statutory benefits for the first 26 weeks after the accident within four weeks after a claimant makes a claim for statutory benefits.
2. Give notice for statutory benefits for the first 26 weeks after the accident within three months after a claimant makes a claim for statutory benefits.

Approximately 99% of claims have had a liability decision made within 90 days of the claim lodgement date. This is consistent by lodgement year (99.1%, 99.3% and 98.4% 2018/19/20). Whilst it is apparent that a liability decision is made within 90 days, signalling compliance with the timeliness of second liability decisions, we are unable to ascertain whether insurers are meeting legislated timeframes for the first liability decision as discussed above.

Table 4.7.2: Detailed assessment by KPI of the implementation of Scheme sub-objective g.1

KPI TITLE	DESCRIPTION	RAG	ANALYSIS	RECOMMENDATIONS
AVERAGE CLAIM DURATIONS	Average claim durations (weeks) from lodgement to closure, separately considering statutory and common law claims.		To assess the early resolution of claims we considered how long it takes for a claim to close after it is lodged. The closure of a claim is dependent on a number of factors including the nature and severity of the injury and the level of recovery of the claimant from their injuries. Claim durations should also be linked with legislative requirements. For example for weekly benefits, at-fault and minor injuries should have an average claim duration of less than 6 months (26 weeks), whereas non-minor claims may have average claim durations of much longer given weekly benefits may be payable for up to three years for injuries with WPI up to 10% or up to five years for injuries with WPI over 10%. Average claim durations from lodgement to closure are *(Qlik, Time duration measures 3 of 3)*: • 40 weeks for statutory claims • 117 weeks for common law claims • 36 weeks for minor not at-fault claims • 39 weeks for at-fault or mostly at-fault claims • 45 weeks for non-minor not at-fault claims These claim durations are broadly similar by insurer. In absolute terms, the claim durations by injury severity and benefit type make sense, with more severe injuries remaining on benefit for longer, and common law claims taking longer to close given extended processes involved compared to statutory benefits.	**Suggestion 32:** We suggest the rate of transition to common law claims is monitored which will impact the cost to the Scheme.

			For minor claims (36 weeks) and at-fault claims (39 weeks), the average claim duration is higher than the legislated benefit of 26 weeks, and this appears to be due to claims receiving ongoing treatment and care benefits. The insurer is allowed to accept further treatment for minor injury claims as per 5.16 of the Motor Accident Guidelines. We are unable to assess the claims durations relative to legislated benefits in more detail at this stage, particularly for non-minor and common law claims due to the relative immaturity of the Scheme, and therefore have rated this aspect as Amber at this stage.	
TIMELINESS INTERNAL REVIEW DECISIONS	Percentage of claims with time between date of complaint and date of resolution for internal disputes less than 28 days.		It takes 23.1 days on average to reach a conclusion for internal disputes, which is in line with statutory limit requirement of 28 days *(Qlik, Insurer internal review (IRR) 5 of 5)*. Although the average number of days to reach a resolution is 23.1 days, only 72% of internal reviews are completed within 28 days across the industry, with a range of 52-94% across individual insurers. This indicates that there are a range of matters being presented, some which are more complex than others that require differing amounts of time to resolve. It may also indicate differing and potentially less mature internal resolution processes for some insurers. The percentage of claims completed within 28 days were 65.7%, 61.7% and 93.5% for lodgement year 2018, 2019 and 2020 respectively. We understand that the improvement in lodgement year 2020 is reflective of SIRA's regulatory action that resulted in remediation activities for some insurers who had systemic delays in internal review decision turnaround times. Some plaintiff lawyers have submitted that the Scheme does not ensure the 'just, quick and cost effective' resolution of claims due to an often complex and bureaucratic process. This invites the possibility of more disputes being brought in the PIC, and therein a delay in payments. Our understanding is that this experience is	**Recommendation 33:** We recommend a reconsideration of the claimant information collection requirements to better inform claims decisions. This could include more detailed collection of the injured person's pre-accident employment details or pre-accident training, skills, and experience. This recommendation should be considered with regard to Recommendation 14 from Clayton Utz's analysis.

limited to the more complex claims and processes within the Scheme including:

- Decisions as to PAWE and the verification of earnings
    - We understand there is no requirement for a claimant to provide adequate evidence of pre-accident earnings, to ensure that PAWE calculations are accurate. In the workers compensation sphere, an insurer can readily contact its insured (the employer) to access pre-injury earnings, whereas within NSW CTP arena the same cannot occur. This creates difficulty in continuing to monitor entitlements and at the same time 'deter fraud.'
- Earning capacity decisions, relevant to the post-second entitlement period.
    - We understand from s 3.7(1) of the Act that to be entitled to weekly benefits for the first two entitlement periods, the claimant must be an 'earner' as per the definition contained within Schedule 1, clause 2. However, for the 'post-second entitlement period,' the requirement to be an earner no longer applies, particularly if the claimant is over the age of 18 – per s 3.8(1)(a). Therefore, the issue becomes about lost 'capacity.' To assess capacity at this stage, without the benefit of the accurate knowledge of someone's employment history, can be difficult. We understand that some insurers are engaging medical assessors to provide 'Earning Capacity Decision' assessments, to assist with these determinations.

Several stakeholders indicated that the timeframes surrounding the application for damages be moved forward, to reduce the overall delays currently experienced in resolution of these claims.

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.

Table 4.7.3: Detailed assessment by KPI of the implementation of Scheme sub-objective g.2

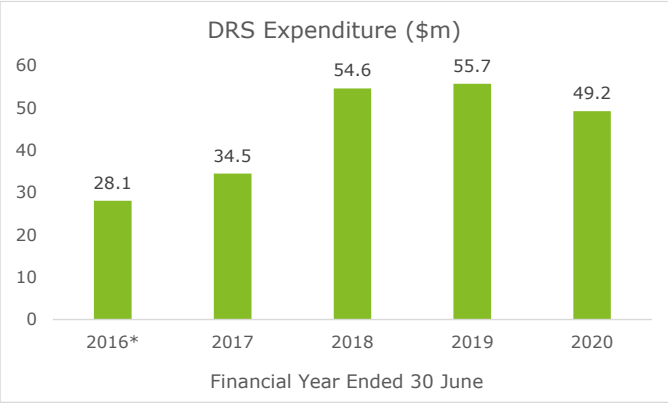
KPI TITLE	DESCRIPTION	RAG	ANALYSIS	RECOMMENDATIONS
FORUM OF DISPUTE RESOLUTION	Number and proportion of disputes that progress from internal review to the PIC (formerly DRS), and the dispute outcomes.		There were 6,299 matched Dispute Resolution Services (DRS) disputes from 12,512 finalised insurer internal reviews (IIRs), indicating 50.3% of internal reviews progress to the DRS during 2018-2020 *(Qlik, IRR and DRS 1 of 2)*. These metrics by lodgement year were: • 2018: 3,446 matched DRS disputes from 4,986 finalised IIRs (69.1%) • 2019: 2,060 matched DRS disputes from 4,639 finalised IIRs (44.4%) • 2020: 793 matched DRS disputes from 2,887 finalised IIRs (27.5%) This indicates that for the slight majority of disputes, the internal review was not effective in coming to an agreement between the claimant and insurer. The lower rate of progression from internal review to DRS in more recent years may be driven by complex cases that have not completed their internal review process. Given the infancy of the Scheme, it is difficult to know whether the rate of progression to the DRS was driven by internal review processes, claimant behaviour or other factors. Note that a claim can have multiple IIRs and multiple DRS disputes. For the purpose of measuring the conversion rate from finalised IIR to DRS, the DRS disputes and the IIRs have been grouped into the high-level dispute areas separately so there may not be one to one mapping between them. 4,065 disputes, including damages, were resolved at the DRS, a finalisation rate of 64.5% *(Qlik, DRS information 3 of 5)*. These metrics by lodgement year are as follows, which shows higher finalisation of older cases as expected: • 2018: 2,569 resolved DRS disputes (74.6%) • 2019: 1,334 resolved DRS disputes (64.8%)	**Recommendation 34**: We recommend increasing the monitoring of a number of key aspects related to claim disputes including: • the number of disputes which progress from internal review to PIC in aggregate and for more granular reasons including WPI assessments, fault status, benefit types, and other key reasons etc. • the number of notices issued to claimants where the insurer views the claimant is in breach of the laws and regulations, and the number of insurer applications to the PIC which allows insurers to recover some legal costs. • the number and duration of matters in backlog that are currently before the PIC **Recommendation 35**: We understand the PIC has acknowledged concerns that the PIC portal has been ineffective as a tool to disseminate required information to relevant stakeholders and is aiming to address these issues in the short-term. We are supportive of these activities being conducted in the short-term. **Recommendation 36**: There are time limits set on claim lodgement, internal review related communications, and a number of other key processes, however, there does not appear to be any time limits on the PIC to resolve disputes. We understand from one submission that under the MACA Scheme there was a requirement for a decision to be made within 15 days of a hearing, and that this requirement has been removed. This

		• 2020: 162 resolved DRS disputes (20.4%) It is noted that whilst the data is as at 31 March 2021, DRS data has not been updated since 14 March 2021 due to the introduction of the Personal Injury Commission (PIC). Several stakeholders submitted that the PIC has been ineffective in resolving disputes in a timely manner. A range of reasons were provided as to why this is the case, including operational concerns such as resourcing, to limitations of operating virtually because of the COVID-19 related lockdowns. We understand the PIC has acknowledged these concerns and is aiming to address these issues in the short-term. We are supportive of these activities being conducted in the short-term. Several stakeholders submitted that the portal used by the PIC is ineffective as a tool to disseminate required information to relevant stakeholders. Some feedback includes that not all stakeholders have access to the same information, or that the information is incomplete which has led to many hearings being rescheduled to later dates. One submission stated that there is also the possibility that any decision made about earning capacity in the statutory benefits sphere, will not ultimately reflect a determination made in the damages claim. This could be to the detriment of the claimant, when it comes to the recovery of amounts paid in statutory benefits. As decisions are based upon limited information, rather than a holistic account of the entire claim, it is easy to see how the claimant could receive an overpayment initially, that is not reflective of what is ultimately assessed for past economic loss.	extends, not only to decisions pertaining to statutory benefits, but to all certificates issued by the PIC, including medical assessment certificates. It was submitted that it is now frequently the experience of participants in the scheme that a Certificate is often issued three months after the actual date of assessment noted on the Certificate. In light of the above, we recommend setting KPIs for the PIC including targets for resolution of disputes (potentially set differently allowing for case type or complexity) within a certain time limit, and monitor the turnaround time (number of days) for the PIC to make a decision. It is noted that the PIC is not governed by the MAIA Act (2017), however it is an integral part of the Scheme. Thus, this recommendation would be appropriate for the Initial Review of the Rules of the PIC of NSW being undertaken from September 2021 to the first half of 2022.

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

To assess the cost-effective resolution of disputes, the KPI framework endeavoured to examine various costs associated with the handling, escalation, and settlement of insurer internal reviews and disputes. However, this data is not collected by SIRA.

SIRA provided information on the cost to operate DRS which is funded from contributions from the Workers Compensation Operational Fund and the Motor Accidents Operational Fund. This is shown in the graph below.



*Linearly annualised 10 months of actual costs ($23.4m)

Expenditure has increased in the MAIA 2017 Scheme compared to the MACA 1999 Scheme by 70%, from an average $31.3m expenditure in 2016 and 2017, to an average $53.2m expenditure over 2018-2020. We note that the 2018-2020 years include $15-20m of expenditure related to 1999 Scheme disputes in respect over prior year injuries may always continue to be expected. We observed an increase in the DRS 'Executive Office' from $7.1m in 2017 to $21.2m in 2018. It is unclear what the additional expenditure is required or used for. Further, while it seems reasonable that in a new Scheme there may be more disputes as stakeholders become more familiarised with the Scheme, it is unclear that this is driving differences in DRS expenditure compared to the old Scheme. It is clear that there is additional DRS expenditure since the commencement of the new Scheme, and per the analysis in sub-objective d.2, a number stakeholders have found a variety of operational issues. This raises a question around the cost-effectiveness of the DRS (now PIC).

There are opportunities to innovate the performance of PIC that should be embraced. There may be areas that require additional expenditure such as improvements to the portal system, and there may be areas of saving if it is unclear what benefit existing expenditure is providing. We recognise this is an operational matter for the PIC and not formally a part of this statutory review.

Recommendation 37: We recommend the following data be collected and monitored to assess cost-effectiveness of the resolution of disputes:

- Cost of insurer internal reviews – average cost per insurer internal review as a proportion of average claim cost for claims that are settled via internal review and do not progress to PIC.
- Settlements with or without dispute – costs of settlements for claims with a dispute compared to claims without a dispute.
- Cost of escalation - average cost per review as a proportion of average claim cost for claims that escalate to PIC review, considering legal representation.

Deloitte.

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.

Table 4.7.5: Detailed assessment by KPI of the implementation of Scheme sub-objective g.4

<table>
<tr><th>KPI TITLE</th><th>DESCRIPTION</th><th>RAG</th><th>ANALYSIS</th><th>RECOMMENDATIONS</th></tr>
<tr>
<td>INTERNAL REVIEW OUTCOMES</td>
<td>Percentage of insurer internal reviews determined in favour of claimant compared to insurer.

Percentage of insurer internal reviews the progress to PIC (formerly DRS).</td>
<td>  </td>
<td>For claims lodged to December 2020, 20.9% of determined insurer internal review (IIR) decisions were overturned in favour of the claimant (Qlik, Insurer internal review (IRR) 3 of 5). This rate has been consistent over the duration of the scheme at 20.8%, 21.7% and 19.9% over lodgement years 2018, 2019 and 2020 respectively.

We note that insurers do not support this KPI, stating that a decision that is overturned by a court may not be related to ‘justness’. We view however that these results are important to observe and analyse for the purpose of understanding how this objective is being met.

A breakdown by the most common IIR types is provided below. It is noted that finalised IIRs include all types of IIRs (including determined, declined and withdrawn IIRs) excluding IIRs in progress. (Qlik, Insurer internal review (IRR) 3 of 5).

A high proportion of IIRS related to whether the claim is a Minor injury. It is also clear that minor injuries and permanent impairment claims are most likely to progress to the PIC (formerly DRS). To this end and considering stakeholder feedback, we included a recommendation regarding consideration of which disputes may not be suitable for IIR.

<table>
<tr><th>Category</th><th>% of determined IIRs</th><th>% of IIR decisions overturned in claimant favour</th><th>% of finalised IIRs that progressed to DRS</th></tr>
</table>
</td>
<td>Recommendation 38: We recommend that a review is conducted into the types of claims that are suitable for internal review compared to those that should proceed directly to the PIC. Medical disputes relating to whole person impairment appears to be one example where disputes should proceed directly to the PIC. The decision on the types of claims that may be considered suitable or optional to the claimant should balance the different Scheme objectives.

We support Clayton Utz’s Recommendation 23 that internal reviews do not apply to a decision relating to the degree of permanent impairment of an injured person (including whether the degree of permanent impairment is greater than a particular percentage).

Recommendation 39: Given 43% of IIRs related to weekly benefit amounts are overturned in favour of the claimant, we recommend a review of weekly benefits calculation / processes to reduce the percentage of internal reviews related to the amount of weekly benefits.</td>
</tr>
</table>

			Minor Injury	35.5%	12.2%	55.0%	
			Treatment and care R&N	27.6%	27.6%	43.3%	
			Mostly at-fault status	7.0%	15.8%	36.1%	
			Permanent impairment	6.7%	3.9%	61.8%	
			Amount of weekly payments	5.5%	43.4%	35.4%	
			Other reasons	17.7%	29.5%	42.0%	
OVERTURNED DISPUTES	Percentage of disputes heard by SIRA's Dispute Resolution Services (DRS) that are overturned.		As at 31 March 2021, considering data from December 2017 to February 2021, 41% of insurer decisions were overturned for claims heard by the DRS *(CTP Insurer Claims and Experience and Customer Feedback Comparison March 2021)*. • 34% of minor claims were overturned. • 46% of treatment and care R&N claims were overturned. • 64% of claims disputing at-fault status were overturned. • 55% of claims disputing the amount of weekly payments were overturned. • 42% of claims for all other disputes were overturned It was observed by Taylor Fry in the report 'Review of Legal Supports' dated 3 September 2021 that 'legally represented claimants have a higher overall rate of success in achieving an overturn of an initially unfavourable decision.' It is noted that this relationship should be treated as a correlation and not necessarily a causation and could be driven by a multitude of factors. Taylor Fry states that there is some		As discussed in sub-objective b.2, we recommend an independent claim file review of claims that did not go through the DRS, however displayed similar characteristics to those that were overturned in favour of the claimant at the DRS to further glean insights into the appropriateness of internal reviews. **Recommendation 40:** We recommend that SIRA investigate the level of understanding by claimants regarding the scheme and its entitlements, including disputation paths. Taylor Fry's report 'Review of Legal Supports' dated 3 September 2021 recommends a comprehensive survey of claimants would be suitable to achieve this.

			evidence of deficiencies from claimants in their understanding of the scheme and their entitlements. Similar to the previous KPI, it is noted that insurers do not support this KPI as *a decision that is overturned may be overturned by a court for many reasons very few of which are related to 'justness'*.	
OVERTURNED LITIGATIONS	Percentage of litigated claims overturned.		SIRA has advised that litigation claims can include the following: • Interstate claims lodged for a motor accident which occurred outside NSW and where the at-fault vehicle is insured by an insurer licensed under MAIA 2017. These claims are covered by the CTP scheme of the State where the accident occurs. • Judicial reviews where a claimant/insurer disagrees with PIC decision (on fault, minor injury, calculation of benefits, etc) on the question of law (rather than facts), they can apply to NSW Supreme Court for an administrative review of that decision. • Damages claims, where a claim for damages can only proceed to court if the PIC has exempted the claim from assessment or has assessed the claim but the insurer/claimant has disagreed with that assessment. Overturns can apply to: • Administrative decision – a claim may be considered overturned if the Court's judicial decision overturns the initial PIC decision. • Damages claim where PIC assessed the claim – a claim may be considered overturned if the amount of damages awarded by Court is different to the amount assessed by PIC. There have been 20 litigated claims to May 2021 *(Qlik, Claims overview 3 of 3)*, where SIRA has informed that the majority of claims are either in progress or were interstate claims where overturns do not apply. There were 6 litigated claims with a finalised court decision by May 2021, of which one claim was overturned. This was	N/A

regarding AAI Limited v Singh [2019] NSWSC 1300, with the summary below:

"***Facts:*** *Mr Singh was injured when the truck he was driving rolled over during a right-hand turn. The accident was caused by an unknown person's incorrect loading of the truck's trailer. On the facts, Mr Singh was not at fault for the motor accident*

Issue: *Do statutory benefits end after 26 weeks if a driver is deemed at fault for the injury by section 3.2(5) of the MAI Act 2017 or section 5.2 for a 'no fault accident'?*

Decision: *The deeming provisions do not end a person's entitlement to statutory benefits after 26 weeks, a person must actually be at fault for the motor accident."*

Procedural fairness was also considered in Briggs v IAG Ltd t/as NRMA [2020] NSWSC 1318, whereby the decision stated that 'it was a denial of procedural fairness to draw an adverse conclusion from new material without notice to the parties'.

Following court decisions, SIRA considers if legislative amendments are required to ensure clarity in the issue which led to litigation. In regard to AAI Limited v Singh [2019] NSWSC 1300, the Motor Accidents and Workers Compensation Legislation Amendment Bill 2021 seeks to address this matter.

It can be viewed that the avenue of litigation accounts for procedural fairness and provides a just outcome regarding the interpretation of the law to which the Scheme follows for both claimants and insurers. We understand that different Scheme participants may differ in their views of what is a just outcome, however court decisions must have the ultimate view on this.

4.8 Objective (h): Collection and Use of Data

Table 4.8.1: Overall assessment of the implementation of Scheme objective (h)

Objective	Overall RAG
(h) To ensure the collection and use of data to facilitate the effective management of the compulsory third-party insurance scheme	

Overall, we view the Scheme is meeting its objective (h) since there has been an appropriate level of information and quality of data collected to facilitate effective management.

The implementation of the 2017 Scheme 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.

SIRA provides a Claims Data Manual which sets out the requirements of insurers to provide data that is imported into and stored within the UCD.

SIRA has stated that the data quality is supervised by:

1. Setting expectations regarding insurer use of the UCD exemption tool, which allows insurers to interrogate their own data submissions, identify any data issues and resolve them in line with legislative and regulatory requirements.
2. Providing each insurer with monthly data quality reporting on the following measures:
    a. Exception breakdowns by tiers and comparison with the industry average
    b. Exception closure rates (how quickly exceptions are closed month on month and compared to industry average)
    c. Open exceptions, nearing 12 months and greater than 1 year
    d. List of highest amounts of observed issues and comparison to previous month
    e. Other exceptions observed and a comparison to the previous month.
3. Holding monthly data meetings with each insurer to:
    a. Discuss open data actions, including updates on data improvement plans, business process reviews and system fixes
    b. Feedback on SIRA identified data quality issues raised in monthly reporting
    c. Joint discussion on scenario-based data usage for specific UCD fields.

To address errors, insurers must provide improvement plans to address data errors in a timely manner. Insurers receive a daily error exception report from SIRA to resolve errors. The ICA has noted that not all data errors are as a result of insurer error. For example:

- Not all information captured neatly fits into UCD categories.
- Information provided by Service NSW generates errors due to differences in the information captured by Service NSW and what is required by UCD.
- At times, incorrect data errors have been received from UCD or data has not been identified as an error leading to bulk errors to be identified later.

The ICA has also stated that for insurers to provide additional data can be a costly and resource intensive exercise, particularly when system upgrades are required or when additional data require insurers to undertake retrospective data collection and collation. Furthermore, insurers view that there must be a clear and transparent framework through which a thorough cost benefit analysis is undertaken before additional data collection requirements are imposed.

An independent claim file review undertaken by John Walsh Centre for Rehabilitation Research (JWCRR); Sydney University and the Centre for Healthcare Resilience and Implementation Science, Australian Institute of Health Innovation, Macquarie University also noted *'There is a need for record/data standardisation to occur across the insurers as without this, fully accurate comparisons in how the Act is being implemented are problematic. This could best be supported by the development of guidelines that specify the documents to be used, including where diagnoses must be recorded, and the actual assessment processes to be performed, such for identifying risk of poor recovery.'*

Whilst we view that there has been an appropriate level of information and quality of data collected to facilitate effective management, there can be further improvements of the standard of collected data and in the collation of data to help monitor the achievement of the Scheme objectives (as discussed in each objective).

Suggestion 41: We suggest an exercise to improve the quality, accuracy, and completeness of the UCD is performed to ensure accurate comparisons between insurers and reduce data errors that are not due to insurer errors. Input from insurers will help align data categories between insurers and reduce administrative burden in the future.

SIRA has utilised the data to provide insights into regulatory compliance and monitoring the scheme performance. For example, systemic delays around internal reviews exceeding their legislative timeframes were identified in two insurers to which remediation activities were implemented and resulting in improved timeframes from these insurers.

Suggestion 42: We suggest that SIRA, with stakeholder input, develop a suite of KPIs that will help facilitate the effective management of the Scheme.

Qlik has been utilised by SIRA to analyse the data collected by insurers regarding claims and payments and continues to build further functionality such as information from the Insurer Scorecard. We have relied on this source of data in the work performed where the majority of our metrics are sourced from and observed discrepancies within Qlik and between other data sources. We queried a particular discrepancy that we viewed as material with SIRA who had stated that "other conditions & exclusion have been applied to it in the background" and these were not included in the Qlik manual (dated October 2019) provided. Discrepancies were also found in number of claims by categorisation between Qlik and EY's Scheme Quarterly Actuarial Pack as at 31 December 2020.

Suggestion 43: We suggest that SIRA updates the Qlik manual to ensure all conditions and exclusions across each metric are documented and clearly understood. We note that in performing our work, we observed that the majority of metrics on Qlik were appropriately documented.

Suggestion 44: We suggest that reconciliations are conducted and are able to appropriately explain differences from Qlik to other work performed, such as from the Scheme Actuary. This will ensure that the analysis performed by SIRA and other parties do not generate conflicting insights and recommendations.

5 Reliances and Limitations

Our work and this report are provided subject to the following limitations and conditions:

- This report should only be used for its intended purpose as described in Part 2 'Terms of Reference' of Clayton Utz' report. No other use of, nor reference to, this report should be made without prior written consent from Deloitte. Deloitte's name or advice should not be used or referred to for any other purpose.

- The report must be considered in its entirety because parts considered in isolation may be misleading. Any copies of this report provided to other parties must be complete copies of the entire report. While due care has been taken in preparation of this report, Deloitte accepts no responsibility for any action which may be taken based on its contents. To the maximum extent permitted by law we are not responsible to you or any other party for any loss you or any other party may suffer in connection with the access to or use of our report by third parties.

- The analysis, findings and recommendations in this report rely upon the accuracy and completeness of all information (qualitative, quantitative, written and verbal) and data supplied to Deloitte by SIRA without independent audit or verification. If the data or other information used in developing this report is misstated or incorrect, then the analysis, findings and recommendations within this report will require review. Should SIRA become aware of any material errors in the data or other information supplied, the author should be advised immediately so that the potential impact of those errors can be assessed.

- This report does not include activities that were out of scope of this report:

    - Review of Scheme reform goals and comparison of MAIA 2017 with MACA 1999,

    - Engagement with SIRA internal staff outside of the project reference group, except as directed by SIRA,

    - Comparison of the Scheme against other CTP or workers compensation schemes,

    - Consultation with other regulators,

    - Financial assessment of proposed changes to the Scheme.

5. CONSOLIDATED RECOMMENDATIONS

5.1 Part A – Design

Recommendation 1

The legislature consider amending the Act to require the Minister to review the Act (and the regulations and guidelines under the Act), on terms similar to the current section 11.13(1), as soon as practicable after the period of 8 years from commencement of the Act and every 5 years thereafter.

***Rationale**: The Scheme is critically important to the users of roads in New South Wales and is in its early stage of maturing. The operation of some aspects of the Scheme has not yet been fully tested, or tested at all. The Scheme should remain under review to make sure that it is working to achieve the objectives of the Act.*

Recommendation 2

SIRA consider developing, implementing and reporting on measures of insurers' procedures to comply, and actual compliance, with overarching obligations relating to statutory benefits claims, including under clauses 4.5, 4.48 and 4.76-77 of the Guidelines, and Division 6.2 of the Act.

***Rationale**: All stakeholders in the Scheme are working to support injured persons who need to access the Scheme and this includes getting the right culture in the handling of claims.*

Recommendation 3

SIRA consider:

(a) amending Schedule 3A of the Guidelines to add an obligation requiring the insurer to report to SIRA on the outcomes of the processes and structures detailed in the insurer's business plan in accordance with clauses 3.16, 3.17 and 3.18 of Schedule 3A of the Guidelines; and

(b) if SIRA has concerns about risk culture and requires insurers to make changes or undertake remedial actions to address those concerns, publishing SIRA's concerns and requirements for insurers.

***Rationale**: Insurers submit plans to meet cultural requirements. They must also be held accountable for achieving those plans.*

Recommendation 4

The legislature consider amending the Act to authorise SIRA to issue Guidelines with respect to the qualifications, education and training, performance assessment, case-loads, and remuneration of insurer personnel involved in decision-making in relation to claims by injured persons.

SIRA should use that power to issue Guidelines including minimum qualification, education, experience and training requirements, restrictions on the criteria for performance assessment and remuneration of such personnel, and standards in respect of case-loads.

***Rationale**: The insurer's staff should be supported to have the capacity, skills and appropriate incentives they need to support injured persons.*

Recommendation 5

The legislature consider amending the Act to authorise SIRA to provide in the Guidelines for:

(a) types of treatment and care that are taken to be reasonable and necessary in the circumstances for the purposes of section 3.24(2) of the Act; and

(b) treatment and care costs, incurred in defined circumstances, that are taken to be reasonable for the purposes of section 3.24(1)(a) of the Act.

SIRA should use that power to issue Guidelines specifying relevant types of treatment and care, and relevant treatment and care costs incurred in defined circumstances.

***Rationale**: Where possible and reasonable, the Scheme must help injured persons to make their own decisions about what is the right treatment and care for them, and help insurers to provide cover for treatment and care with a minimum of formality where the circumstances reasonably allow.*

Recommendation 6

The legislature consider amending the Act to provide that treatment or care recommended in writing by a treating practitioner is, subject to evidence to the contrary:

(a) presumed to be reasonable and necessary in the circumstances; and

(b) if certified by the treating practitioner, presumed to relate to the injury resulting from the motor accident concerned.

The amendment should provide for SIRA to specify in the Guidelines circumstances in which one or both of the presumptions do not apply.

***Rationale**: A doctor or other treating practitioner is generally the best person to decide what treatment and care someone needs. Injured persons should generally have the choice as to whether to accept the recommendations of their treating practitioners.*

Recommendation 7

The legislature consider amending the Act, in relation to determining whether any treatment and care provided to the injured person in accordance with a written recommendation by their treating practitioner is reasonable and necessary in the circumstances or, if certified by the treating practitioner, relates to the injury resulting from the motor accident concerned:

(a) to prohibit insurers from requesting the injured person to undergo a medical or other health related examination;

(b) to allow insurers to request additional information from a treating practitioner; and

(c) to provide that an insurer who wishes the injured person to undergo a medical or other health related examination must lodge a medical dispute with the PIC.

The amendment should provide for SIRA to specify in the Guidelines circumstances in which the restriction in (a) does not apply.

***Rationale**: A doctor or other treating practitioner is generally the best person to decide what treatment and care someone needs. The Scheme needs to support insurers to rely on information given by treating practitioners.*

Recommendation 8

SIRA consider:

(a) developing a panel of rehabilitation providers and occupational therapists, contracted to SIRA and not insurers, who would have responsibility to provide any:

(i) rehabilitation assessment;

(ii) assessment to determine attendant care needs; or

(iii) assessment to determine functional and vocational capacity; and

(b) amending the Guidelines to provide that, for the purposes of sub-sections (b) and (c) of section 6.27(1) of the Act, any assessment of these matters otherwise than by a treating practitioner must only be undertaken by a member of the panel (or an employee or contractor of a member of the panel).

***Rationale**: Persons playing a key role in helping recovery should be independent so that they are supported to focus on understanding the needs of the injured person.*

Recommendation 9

SIRA amend Part 4 of the Guidelines to:

(a) prohibit insurers or any person appointed by insurers from attending a private consultation between an injured person and a treating practitioner occurring in the ordinary course of the injured person's treatment and care that relates to the injury resulting from motor accident concerned; and

(b) require insurers to give written notification to the injured person concerned of any communication (whether written or otherwise) between the relevant insurer and an injured person's treating practitioner, including the matters discussed and the outcome of the communication.

***Rationale**: The practitioner/patient relationship is private and confidential.*

Recommendation 10

SIRA consider taking steps to ensure compliance by insurers with their obligations under clauses 4.76 to 4.90 of the Guidelines relating to recovery plans for injured persons, and to ensure that recovery plans are of a high standard and address not only return to work but also return to other activities.

***Rationale**: A plan for recovery will help injured persons.*

Recommendation 11

SIRA consider:

(a) consulting with relevant medical stakeholders and, if considered necessary, undertaking research to determine the extent to which certain treatment and care is not reasonably available at AMA rates; and

(b) whether it is necessary to amend clause 4.95 of the Guidelines to ensure that insurers pay the reasonable cost of treatment and care above AMA rates in circumstance where equivalent treatment or care is not reasonably available at AMA rates.

***Rationale**: Insurers should pay for the treatment and care that is needed and available.*

Recommendation 12

SIRA consider undertaking research to determine precisely the barriers to participation in the Scheme by providers of treatment and care, and the measures that could be taken to remove or reduce those barriers, in order to enable injured persons to have the provider of their choice.

***Rationale**: All providers of treatment and care should be supported to participate in the Scheme.*

Recommendation 13

SIRA should amend clause 4.99 of the Guidelines to clarify that the insurer is required to issue its decision in relation to treatment or care within 10 days of receipt of the claimant's request, whether the request is for pre-approval to pay statutory benefits for the treatment or care or for the payment of statutory benefits for treatment or care that has already been provided.

***Rationale**: Decisions about treatment or care affect the health and wellbeing of injured persons and must be quick.*

Recommendation 14

SIRA should undertake a review of the weekly payments framework, to assess what steps can be taken to enable a greater proportion of earners to receive their full entitlement sooner and to minimise disputes. The review should consider, among any other matters considered relevant, whether:

(a) the provisions for determining the appropriate amount of weekly payments for earners can be simplified, including consideration of whether weekly payments should be made on the basis of a set statutory rate, or rates dependent on the nature of the injured person's pre-accident employment or pre-accident training, skills and experience;

(b) the provisions for calculating weekly payments in the post-second entitlement period remain appropriate;

(c) the Act or Guidelines should be amended to enable faster and better access to relevant information by insurers for the purpose of calculating the required amount of weekly benefits; and

(d) guidance is required as to how disputes in relation to weekly benefits should proceed in the PIC, having regard to the provisions currently in clauses 1(a) and 2(d) of Schedule 2 to the Act.

***Rationale**: There is now enough experience in the Scheme to refine the provisions governing financial support by way of weekly payments. Many stakeholders agree that the provisions present a range of difficulties and can be improved. This could lead to faster and better handling of claims from the perspective of injured persons.*

Recommendation 15

The legislature consider amending the Act to make weekly payments of statutory benefits payable in respect of the period before the claim is made even if the claim is made more than 28 days after the date of the motor accident, if the claimant provides a full and satisfactory explanation for the delay.

***Rationale**: An inflexible rule for the timing of claims can operate unfairly for some of the most seriously injured persons.*

Recommendation 16

SIRA should amend the Guidelines to clarify that the relevant insurer must begin weekly payments of statutory benefits immediately after determining that a claimant is an earner entitled to weekly payments under section 3.6(1), including by making interim payments if the full entitlement has not yet been determined.

***Rationale**: Financial support should begin to flow as soon as the insurer has confirmed that an injured person is entitled to it.*

Recommendation 17

SIRA should undertake a review of the lodgement of damages claims under Part 4 of the Act which should:

(a) proceed on the basis that section 6.14 of the Act should be amended to remove the requirement for persons with whole person impairment 10% or less to wait 20 months before lodgement and section 6.23(1) of the Act should be amended to remove the 2-year prohibition on settling claims for damages; and

(b) consider, among any other options considered appropriate for consultation, amendments to the Act that would have the following effect:

  (i) an injured person with non-minor injuries wishing to claim damages for past economic loss only (i.e. not seeking to claim damages for future economic loss or for non-economic loss) could do so at any time;

  (ii) insurers be required to assist injured persons who are unlikely to have been wholly at fault and unlikely to have whole person impairment greater than 10% to lodge a claim for damages of the above nature upon the injured person's return to work within the first 12 months after the motor accident concerned; and

  (iii) any persons wishing to claim damages for future economic loss or damages for non-economic loss (in addition to damages for past economic loss) could do so only 12 months or more after the motor accident concerned; and

  (iv) despite sub-paragraph (iii), if a person is assessed within the first 12 months after the motor accident concerned as having a degree of permanent impairment greater than 10% as a result of the accident, then they may claim damages at any time.

(c) consider whether section 6.25 of the Act should be amended in respect of the timing and content of the claimant's obligation to give particulars of a damages claim.

***Rationale**: All stakeholders agree that waiting 20-months to claim damages impacts injured persons and creates problems for insurers and the dispute-resolution system. Careful consideration is needed for additional changes that may be required if the 20-month wait is removed.*

Recommendation 18

The Minister consider the making of a regulation under section 4.9(2)(a) of the Act to specify a discount rate lower than 5% and which properly qualifies the present value of future economic loss.

***Rationale**: A higher discount rate has the most significant impact on financial support for the most severely injured persons – particularly those who are younger.*

Recommendation 19

The legislature consider amending section 2.25 of the Act to align with Part 2 of Schedule 4 to the Act, to enable Guidelines made under section 2.25 to adopt the mechanism and procedure for profit adjustment in place under the TEPL Guidelines.

***Rationale**: It is important that the mechanism to adjust insurer profits is clearly drafted and works appropriately.*

Recommendation 20

The legislature consider amending clause 2 of Part 2 of Schedule 4 to the Act, to provide expressly that SIRA may exercise a power under clause 2 relating to third-party policies in force during the transition period, either during or after the transition period.

***Rationale**: It is important that the mechanism to adjust insurer profits is clearly drafted and works appropriately.*

Recommendation 21

SIRA undertake a consultation to report on any barriers in the Scheme to innovation in the setting of premiums and other aspects of the conduct of CTP insurance business, and the extent and manner in which removal of those barriers would affect:

(a) affordability; and

(b) the flexibility and incentive for insurers to innovate in ways that advance the objectives of the Act and encourage safer driving decisions.

***Rationale**: The motorists of New South Wales will benefit from innovation in CTP business to achieve the objectives of the Act and encourage road safety. This should be the subject of ongoing work to understand how to support insurers in their efforts to innovate.*

Recommendation 22

The legislature consider amending section 6.2(2) of the Act to amend the minimum requirement for a satisfactory explanation for failure to comply with a duty to: a reasonable person in the position of the claimant would have been justified failing to comply with the duty.

***Rationale**: The claims obligations on injured persons should operate fairly, so that those who act reasonably are protected from harsh consequences.*

Recommendation 23

The legislature consider amending section 7.9 of the Act to provide that Division 7.3 of the Act (Internal review) does not apply to a decision relating to the degree of permanent impairment of an injured person that has resulted from the injury caused by the motor accident (including whether the degree of permanent impairment is greater than a particular percentage).

***Rationale**: It is in the interests of all parties that decisions are made by persons who are best qualified to make them.*

Recommendation 24

The legislature consider amending each of sections 7.11(3), 7.19(3) and 7.41(3) of the Act to provide that, in addition to the regulations already permitted by those sections, the regulations may prescribe circumstances in which section 7.11, 7.19 or 7.41 (as the case may be) does not apply (thus having the effect that, in the prescribed circumstances, a claimant may proceed directly from the insurer's initial decision on a matter to dispute resolution under Division 7.4, Division 7.5 or Sub-division 3 of Division 7.6).

Rationale*: The internal review mechanism is an important aspect of the Scheme but mandatory internal review is not appropriate in all circumstances.*

Recommendation 25

The Minister consider the making of regulations under sections 7.11(3), 7.19(3) and 7.41(3) of the Act, as amended in accordance with Recommendation 24, to prescribe the circumstance where the claimant and relevant insurer are in a dispute of a category that has already been the subject of an internal review in relation to the claim.

Rationale*: The internal review mechanism is an important aspect of the Scheme but mandatory internal review is not appropriate in all circumstances.*

Recommendation 26

The legislature consider amending the Act to provide that the Guidelines may prescribe maximum acceptable overturn rates in relation to a licensed insurer's statutory benefits decisions that are the subject of merit review, medical assessment and miscellaneous claims assessment under the Act on referral by the claimant.

Rationale*: The Scheme should support insurers to continue to strive to make the right decisions.*

Recommendation 27

SIRA should issue Guidelines setting maximum acceptable overturn rates in relation to statutory benefits decisions that are the subject of merit review, medical assessment and miscellaneous claims assessment under the Act on referral by the claimant. The Guidelines should:

(a) specify the maximum acceptable overturn rates, which may be separate rates for merit review, medical assessment and miscellaneous claims assessment matters;

(b) specify that:

  (i) 'overturn' means that the decision of the merit reviewer, medical assessor or the Commission is more favourable to the claimant than the insurer's decision;

  (ii) 'overturn rate' of an insurer means the ratio of 'overturned' decisions by the insurer in a given period to the number of statutory benefits claims managed by the insurer in the same period (including claims managed on behalf of the Nominal Defendant or other insurers).

  (iii) overturn rates include disputes that are withdrawn after the referral by the claimant, if the withdrawal follows a change by the insurer to the decision under dispute. Withdrawals under those circumstances must be notified to SIRA by the insurer; and

  (iv) overturn rates do not include any decision where:

    (A) the merit reviewer, medical assessor or the Commission certifies that information that was material to the decision was not available to the insurer when the decision under dispute was made; or

    (B) in respect of a dispute that is withdrawn after the referral by the claimant and following change by the insurer to its decision, the insurer satisfies SIRA that the change to its decision followed the provision of information

that was material and was not available to the insurer when it made the decision that was under dispute;

(c) provide that SIRA will continuously monitor, and publish on its website, the overturn rates of each licensed insurer, and may obtain information from licensed insurers and the Commission for that purpose;

(d) provide for SIRA to require remedial action by the insurer in the event that the overturn rate in respect of the insurer's decisions in any 6 month period exceeds the relevant maximum, and provide that a failure to undertake the required remedial action is a breach of the Guidelines; and

(e) provide that, if a licensed insurer exceeds an overturn rate across any 12-month period, this constitutes a breach of the Guidelines.

***Rationale**: The Scheme should support insurers to continue to strive to make the right decisions.*

Recommendation 28

The legislature consider amending Subdivision 3 of Division 7.6 of the Act to adopt a simpler approach to the drafting of the provisions governing miscellaneous claims assessment, in particular having regard to the current section 7.42(2).

***Rationale**: The drafting of the Act should not be more complex than is needed to give effect to the Scheme design.*

Recommendation 29

SIRA should undertake a consultation to determine changes to the Scheme that directly facilitate and incentivise the use of joint medico-legal assessments in relation to claims for damages, as well as a program of data collection to assess the efficacy of the changes.

***Rationale**: Joint medico-legal assessments may not be appropriate in every case but they have the potential to support the claimant's experience and encourage the early resolution of motor accident claims and the quick, cost-effective and just resolution of disputes.*

Recommendation 30

SIRA should develop and consult on recommended changes to the provisions of the Act and Regulations that govern the provision of legal support in the Scheme.

***Rationale**: Scheme outcomes and injured persons' experience in the Scheme will often benefit from access to the services of an adviser and advocate.*

Recommendation 31

SIRA should amend the Guidelines to require the relevant insurer for a claim to include contact details for the Independent Review Office and a description of the service provided by the Independent Review Office in respect of complaints about insurers in:

(a) the written notice to the claimant under section 6.19(1) of the Act; and

(b) each written notice to the claimant of a decision:

(i) to decline to pay a statutory benefit that was claimed, or to cease paying statutory benefits (including on the basis of minor injury or fault);

(ii) not to approve treatment and care, or not to approve treatment and care in full;

(iii) relating to the amount of weekly payments payable to the claimant, unless the decision is to pay an amount equal to an amount that was claimed; and

(iv) as to the degree of permanent impairment of the claimant, if the decision is not consistent with opinion submitted to the insurer by or on behalf of the claimant.

***Rationale**: Insurers should tell injured persons about their options to resolve complaints.*

Recommendation 32

SIRA should develop and issue a public statement of its policy as to when it may comment publicly on its regulatory activities. SIRA's policy should include, among any other elements considered appropriate, its position on publication of the following, subject to circumstances in which it is against the public interest to do so:

(a) regulatory notices and letters of censure;

(b) civil penalties and other formal regulatory action, together with an outline of reasons for their imposition;

(c) an outline of any remediation plan opened in relation to a regulatory notice;

(d) the outcomes of any remediation plan opened in relation to a regulatory notice; and

(e) the outcome of any referral by the Independent Review Office to SIRA of a significant matter.

The policy should also address the circumstances in which SIRA may comment publicly, or will not comment publicly, on investigations.

***Rationale**: Informing the public of SIRA's regulatory activities is important because it promotes public confidence in SIRA's administration of the law, and compliance with the law by informing the public about the standards SIRA expects and the consequences of failing to meet those standards.*

Recommendation 33

SIRA should develop and issue a public statement of its policy for the publication of information about assessment of insurer profit under the TEPL Guidelines and section 2.25 of the Act (including information about insurer profit and SIRA's decision-making), as well as information about the application of clause 8 ('Innovation Support') of the TEPL Guidelines.

***Rationale**: The Scheme would benefit if SIRA were to set expectations in relation to disclosure of insurer profits and the reasons for its position.*

Recommendation 34

The Minister consider the making of an amendment to the regulations to remove 'adjustment disorder' from the definition of 'minor injury'.

***Rationale**: The definition of 'minor injury' must only include conditions that are expected, with appropriate treatment and care, to resolve within 6 months after the motor accident concerned.*

Recommendation 35

SIRA should amend clause 5.4 of the Guidelines for clarity, so that the clause reads: *Insurers should not require injured persons to undergo diagnostic imaging for the purpose of the insurer determining whether the injury related to the claim is a minor injury.*

***Rationale**: Claim managers should be supported to understand correctly the restriction on the use of diagnostic imaging.*

Recommendation 36

The legislature consider amending the Act to provide that all injured persons may claim damages if the injuries caused by the motor accident result in a degree of permanent impairment greater than 10%.

***Rationale**: The Scheme should give all seriously injured persons (with a degree of permanent impairment greater than 10%) a right to claim damages for ongoing pain, suffering, loss of amenities or loss of expectation of life.*

Recommendation 37

The legislature consider amending sections 3.11 and 3.28 in Part 3 of the Act to extend to 52 weeks the current 26-period of statutory benefits for persons with minor injuries only.

***Rationale**: The minor injury framework requires refinement to ensure that it applies to injured persons in the way that the Scheme intends.*

Recommendation 38

SIRA should undertake a consultation to identify an alternative term for 'minor injury', with a view to proposing that the term be changed.

***Rationale**: The term 'minor injury' is not appropriate to describe what, for many injured persons, are significant injuries.*

Recommendation 39

The legislature consider amending the Act to provide that, in circumstances where an insurer wishes to reverse its decision – adversely to the claimant – as to whether the injuries caused by the motor accident are minor injuries exclusively for the purposes of Part 3 of the Act (Statutory benefits), and more than 18 months have passed since the motor accident concerned, the insurer must refer the matter to the Commission for medical assessment and must not cease paying statutory benefits (unless otherwise permitted to do so under the provisions of the Act) until such time as a medical assessor issues a certificate as to the matter, to the effect that the claimant's injuries are minor injuries exclusively.

***Rationale**: Insurers should be able to change their decisions in light of new evidence, but in some cases a new decision should be confirmed by someone independent.*

Recommendation 40

The legislature consider amending Part 3 of the Act to:

(a) extend to 52 weeks the period for which statutory benefits are available to injured persons who are wholly or mostly at fault; or

(b) remove altogether the restrictions on the entitlement to statutory benefits of injured persons who are wholly or mostly at fault.

***Rationale**: The Objectives of the Scheme are to support all injured persons, and the Scheme could benefit by removing the need to determine fault in statutory benefits claims.*

Recommendation 41

The legislature consider amending the Act to allow SIRA to issue Guidelines providing for the payment of statutory benefits for treatment and care after 26 weeks to injured persons who are wholly or mostly at fault, in specified circumstances.

***Rationale**: The 26-week time limit can prevent access to treatment and care benefits where there is a delay that is not the fault of the injured person.*

Recommendation 42

SIRA should issue Guidelines specifying that, in circumstances of delay caused by non-compliance by the relevant insurer with claim handling provisions, statutory benefits for treatment and care after 26 weeks are payable to injured persons who are wholly or mostly at fault to the extent that the expenses are incurred after 26 weeks due to the insurer's delay.

***Rationale**: The 26-week time limit can prevent access to treatment and care benefits where there is a delay that is not the fault of the injured person.*

Recommendation 43

The legislature consider amending the section 3.37 of the Act to provide that statutory benefits are not payable to an injured person after the person has been charged with or convicted of a serious driving offence that caused or contributed to the motor accident.

***Rationale**: The current version of section 3.37 operates as a punishment for offending conduct, rather than as a prohibition on statutory benefits that would be payable as a result of offending conduct.*

Recommendation 44

The Minister consider issuing a public statement, through SIRA, of the outcome of Recommendation 6 made by the Law and Justice Committee in its 2018 review of the Scheme.

***Rationale**: The restrictions on access to statutory benefits by foreign residents continues to be a matter of concern to stakeholders, including lawyer and insurer groups. The Scheme would benefit from a public statement of the Government's position on the issue.*

Recommendation 45

SIRA consider developing a panel of trauma support specialists with training and expertise in both trauma counselling and the Scheme. In the event of a death or catastrophic injury resulting from a motor accident, a trauma counsellor would be made available to assist family members of the deceased or injured person to take necessary steps in the period following the event to care for their psychological wellbeing as well as to assist in their early engagement with the relevant insurer.

***Rationale**: The family of deceased or catastrophically injured persons should have specialised support to avoid poor outcomes in the Scheme.*

Recommendation 46

The legislature consider amending section 1.6 of the Act (Meaning of 'minor injury') to provide that a psychological or psychiatric injury resulting from the death or catastrophic injury of a family member is not a 'minor injury' for the purposes of the Act.

***Rationale**: The Scheme should minimise unnecessary stress on grieving family members.*

Recommendation 47

The legislature consider amending Division 9.4 of the Act to provide that, in addition to existing provisions requiring the Nominal Defendant to discharge the obligations of a person insured under a third-party policy issued by an insolvent insurer, the Nominal Defendant is to discharge the obligations of the insolvent insurer:

(a) under Part 3 of the Act; and

(b) under any agreement entered into with the Lifetime Care and Support Authority under section 3.45(2) of the Act.

***Rationale**: The insolvency provisions of the Act need refinement to deal expressly with the liabilities of insurers to injured persons, in addition to liabilities to pay damages.*

Recommendation 48

The legislature consider amending section 9.10 of the Act to:

(a) remove the limitation on the section, so that it does not only apply "instead of suspending the insurer's licence";

(b) provide that the licensed insurer concerned must be given an opportunity to make written submissions to SIRA with respect to the alleged contravention; and

(c) remove the requirement on SIRA to refer the matter to a special committee for advice.

***Rationale**: SIRA should have an efficient and effective power to impose penalties and censure behaviour of insurers that warrants that action. The process governing SIRA's power to impose a civil penalty should align with other, similar, legislation.*

Recommendation 49

The legislature consider amending the Act to insert a new object of the Act under section 1.3(2) in Division 1.1 as follows:

(i) to promote the prevention of motor accidents, and safety in the use of motor vehicles.

***Rationale**: All stakeholders in the Scheme, and the Scheme itself, will benefit from safer roads and a reduction in the occurrence and severity of injuries from motor accidents.*

Part B - Implementation

The below table provides a full list of Deloitte's recommendations and suggestions in respect of implementation of the Scheme.

A "suggestion" is an idea or new approach which if undertaken could potentially improve the operation of the Scheme in line with its objectives however the impact to different stakeholders is not expected to be material.

A "recommendation" is intended to have more weight than a suggestion as it will likely improve the operation of the Scheme in line with its objectives and/or relates to a matter of relatively higher materiality and/or risk.

Index	Sub-Objective	Type	Recommendation / Suggestion
1	a	Recommendation	We recommend the ongoing use of independent claim file reviews as this provides the most effective means of assessing this objective. Some key areas we recommend that the independent claim file review cover includes declined claims for treatment and care benefits, claims that go through the dispute resolution process, and claims that are 'cash settled'. While the claims portfolio appears to have been fairly represented through existing independent claim file reviews, a deeper focus on reviewing claims in these key areas will provide the greatest insight for further improvement to the Scheme. We are of the position that SIRA is best placed to decide if SIRA engages an external independent body or if SIRA, as an independent authority, undertakes a review.
2	a.1	Suggestion	From a health outcomes point of view, recovery plans can be beneficial to the claimant. Further, given that there are reported inconsistent processes for the implementation of recovery plans across the Scheme, we suggest a review is conducted to understand best practice recovery plan processes and documentation and share this with all key stakeholders. This suggestion is aligned and in complement to Recommendation 10 of Clayton Utz's analysis.
3	a.2	Recommendation	Collect data separately for declinatures of weekly benefits and treatment and care benefits to monitor the declinature rates for these benefits for not at-fault non-minor claimants, after being on benefits for 26 weeks.
4	a.2	Suggestion	Make available the data to measure this KPI. Further, we suggest monitoring the extent to which actual treatment and care provided to injured persons differs from medical advice, and the extent to which medical advice differs where multiple opinions are sought. This may be an area which can be included as part of claim file
5	a.2	Suggestion	While complaints emanate from a small proportion of claims, we suggest more detailed monitoring and analysis of the underlying drivers of complaints to

			understand the extent and situations in which injured persons have not viewed their treatment and care was appropriate.
6	a.2	Suggestion	In the 'CTP Insurer Claims Experience and Customer Feedback Comparison', we suggest that complaint volumes are expressed as a percentage of lodged claims rather than on all Green Slips. This would provide a more meaningful statistic since most complaints are in respect of lodged claims.
7	a.2	Recommendation	NPS and CES scores indicate that CTP Assist has been an effective mechanism. Some stakeholder submissions and discussions indicated some areas for improvement in CTP Assist, including the accuracy of information provided, primarily related to more complex matters. We recommend a review of whether a complex claims case team with expertise in supporting matters such as weekly benefit calculations, would further enhance the capability of CTP Assist, in order to help injured persons better navigate the NSW CTP Scheme and understand their benefit entitlements. This recommendation is in complement to Recommendation 45 of Clayton Utz's analysis.
8	a.2	Recommendation (mentioned in CU Recommendation 32 (c))	We recommend, in-line with an option suggested by Taylor Fry in their Review of Legal Support, for CTP Assist to have an expanded role and be more proactively promoted as the first point of call for injured people. This is to ensure that more claimants are aware of all their benefits, including regarding disputes, and can navigate their claims journey more effectively.
9	a.3	Suggestion (aligned with CU Recommendation 35)	We understand SIRA is currently working to develop RTW definitions and measures which may be aligned across the CTP and Workers' Compensation schemes. This will allow more effective measurement and monitoring of RTW rates to produce insights that may inform improvements which provide better outcomes for injured persons. Deloitte are supportive of this work.
10	a.3	Suggestion	We suggest that as part of the development of RTW measures, that stay at work measures for 4, 13, 26 and 52 weeks are included as part of that process.
11	a.3	Suggestion	We suggest that as part of SIRA's development of RTW measures, that return to pre-accident activities capacity is measured, including everyday activities but also activities that the injured had usually partaken in and enjoyed pre-accident (or continue to produce this report annually).
12	b.1	Recommendation	We recommend analyses of the profile of declined claims, particularly those that lodged a late claim to understand whether these are vulnerable customers that need assistance, or due to another underlying reason, which will assist in assessing whether the current measures are sufficient for ensuring injured

			road users understand how to access the system and their entitlements. Some stakeholders submitted they had observed poor literacy and an inability to use email in some claimants. Some stakeholders submitted that some claimants have difficulty completing claim forms in the first month after the injury due to the physical and psychological effects of pain and pain medication, which may be exacerbated by more complex aspects such as calculations of weekly income earnings.
13	b.1	Suggestion	We suggest that SIRA updates the animation series to include information on the PIC to assist potential claimants navigate this element of the Scheme.
14	b.1	Recommendation	We recommend the collection of data on the timing of the first and second liability decision separately, to monitor compliance with both the first and second liability decision as per 6.19 of the Act.
15	b.2	Recommendation	The metrics and analysis reveal benefits are generally being paid consistent with legislative requirements, which provides for more benefits to be paid to more severely injured claimants. The metrics consider claimants that are on benefits. We recommend monitoring of the proportion of **claimants that have not recovered or been able to return to work** (not just those on benefits) from their injury and have **not** been paid benefits within each of the categories considered. We would expect this proportion to be small, except perhaps for minor and at-fault / mostly at-fault claims where benefits entitlements are limited, however it is for this proportion of claims that are potentially not receiving ongoing financial support that may be in need. Whilst our analysis does not consider the appropriateness of the duration of benefit payments in regard to the legislations, we support Recommendation 37 and Recommendation 40 of Clayton Utz's analysis which recommends changes to persons with minor injuries and those that were wholly or mostly at-fault.
16	b.2	Recommendation	Given 41% of insurer decisions are overturned, we recommend an independent claim file review consider whether claimants were provided adequate ongoing financial support for their particular needs and circumstances, focussing on claims that were not disputed at the DRS, however displayed similar characteristics to those that were overturned in favour of the claimant at the DRS to further glean insights into the appropriateness of insurer internal reviews. We are in support of Recommendation 26 and 27 of Clayton Utz's analysis which recommends the setting of maximum acceptable overturn rates in relation to statutory benefits decisions that are the subject of merit

			review, medical assessment and miscellaneous claims assessment under the Act on referral by the claimant.
17	c	Suggestion	Consistent with the ICA submission, we suggest monitoring of: • the detection rate of non-compliance with registration and insurance requirements • the annual number of breaches of the requirements for registration and insurance detected and actioned by NSW Police. These measures will provide insights into both detection and compliance behaviour and may offer additional value when considered in concert with measures relating to affordability (such as utilisation of short-term registration).
18	c	Suggestion	Consistent with the ICA submission, we suggest monitoring of: • the utilisation of the nominal defendant Scheme • measure of the number of claims received under the uninsured nominal defendant provision (to be used with the previous suggestion in objective (c)).
19	d	Recommendation	CTP insurance is a product that provides benefits to society though sold for profit, and the ideal outcome is that all participants act with integrity to assist balancing those objectives. There is at least a perception amongst claimant representatives that the balance of power lies with the insurers on disputed matters. It is recommended that insurers continue to develop cultures where policyholders are treated fairly and compassionately.
20	d.1	Recommendation	Given the relatively higher level of affordability of NSW CTP premiums, there is the potential that some premium increases may be absorbed by policyholders whilst still meeting the affordability objective. We recommend any review of premiums balances the Scheme objectives, including affordability, to encourage early and appropriate treatment and care, financial support for injured persons, to achieve optimum recovery of persons from injuries sustained in motor accidents, and to maximise their return to work or other activities.
21	d.1	Recommendation	Conduct another review into the reasons for lower claims frequency in the Scheme compared to the original Schedule 1E parameters. For example, whether there is different experience observed in data from hospitals across different geographical locations, which may help create a link to claim reporting patterns for vulnerable people such as those who require an interpreter or other assistance. Further we recommend that SIRA make it a requirement that insurers accurately record for each claim the 'Interpreter

			Required' field, which may be used to support this analysis.
22	d.1	Recommendation	We recommend that SIRA maintains its discretion to trigger the TEPL mechanism, with due reference to advice from the scheme Actuary and Premium Committee. We are supportive of comments made by SIRA's chief executive at the Law and Justice Committee hearings that activation of the TEPL mechanism will be conducted at interim annual reviews once desired confidence levels are achieved.
23	d.2	Recommendation	Minor injury assessments are completed until up to around three months after being reported which can result in reclassification of claims. Given also that 55% of internal reviews were referred to the DRS (now PIC) and the operational and legal costs incurred for these claims, we recommend an independent claim file review is conducted to understand the drivers of minor injury claim disputes and the associated cost of these.
24	e.1	Recommendation	We recommend that consideration be put forth to simplify both the full and interim premium filing process in the Motor Accident Guidelines. This can encourage competition amongst the market by increasing price competition amongst existing insurers and providing potential new entrants with less administrative burden.
25	f	Recommendation	We recommend that SIRA engage with insurers and NSW Police to identify the most efficient way of accessing the information and data pertaining to potentially fraudulent claims, and to the extent it will be released to the claimant. For example, a portal system could be set up for release of all police investigations relating to a matter in which a CTP claim is made, once investigations are completed. This would avoid the need for making multiple Government Information (Public Access) Act 2009 (GIPA) applications which require authorisation by the parties and lead to highly relevant police outcomes, particularly with regard to suspected fraudulent claims, being available to insurers in the early stages of investigating a claim.
26	f	Recommendation	We recommend a thorough investigation into the extent and nature of fraud and potential fraud which will then form the basis of accountabilities, roles and responsibilities in respect of fraud deterrence across all Scheme participants.
27	f	Suggestion	Monitor certain key metrics (detective), for example: • 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. As described above, while this ratio is available at a high-level, the ratio for 2020 appears unusually low and more analysis is necessary.
28	f	Suggestion	Implement specific fraud deterrence initiatives (preventative), for example: • Dissemination of monitoring insights to the public. • Education around the criminality of exaggeration of injury or losses in insurance claims.
29	f	Suggestion	Monitor reasons for withdrawal of claims, applications for insurer internal reviews, and disputes with the PIC, for indications of fraudulent elements in claims.
30	g	Suggestion	We suggest that monitoring of average caseloads per claimant be formalised into reporting to understand the effect this may have on the resolution of claims. A balance should be targeted and incentivised with caseloads being set in a way that allows the resolution of claims, early and appropriately. This suggestion is viewed in complement to Recommendation 4 in Clayton Utz's analysis.
31	g	Suggestion	We suggest that monitoring is conducted on the number or proportion of applications for additional costs outside what is permitted by the Regulations (16 monetary units which is currently the equivalent of $1,660.16), where it is asserted that the matter involves 'exceptional circumstances' under s 8.10(4)(b), to gain insight into the nature of claims where this is most prevalent and therefore whether there are areas to improve in Scheme design and / or operation.
32	g.1	Suggestion	We suggest the rate of transition to common law claims is monitored which will impact the cost to the Scheme.
33	g.1	Recommendation	We recommend a reconsideration of the claimant information collection requirements to better inform claims decisions. This could include more detailed collection of the injured person's pre-accident employment details or pre-accident training, skills, and experience. This recommendation should be considered with regard to Recommendation 14 from Clayton Utz's analysis.
34	g.2	Recommendation	We recommend increasing the monitoring of a number of key aspects related to claim disputes including: • the number of disputes which progress from internal review to PIC in aggregate and for more granular reasons including WPI assessments, fault status, benefit types, and other key reasons etc. • the number of notices issued to claimants where the insurer views the claimant is in breach of the laws and regulations, and the number of insurer applications to the PIC which allows insurers to recover some legal costs.

			• the number and duration of matters in backlog that are currently before the PIC.
35	g.2	Recommendation	We understand the PIC has acknowledged concerns that the PIC portal has been ineffective as a tool to disseminate required information to relevant stakeholders and is aiming to address these issues in the short-term. We are supportive of these activities being conducted in the short-term.
36	g.2	Recommendation	There are time limits set on claim lodgement, internal review related communications, and a number of other key processes, however, there does not appear to be any time limits on the PIC to resolve disputes. We understand from one submission that under the MACA Scheme there was a requirement for a decision to be made within 15 days of a hearing, and that this requirement has been removed. This extends, not only to decisions pertaining to statutory benefits, but to all certificates issued by the PIC, including medical assessment certificates. It was submitted that it is now frequently the experience of participants in the scheme that a Certificate is often issued three months after the actual date of assessment noted on the Certificate. In light of the above, we recommend setting KPIs for the PIC including targets for resolution of disputes (potentially set differently allowing for case type or complexity) within a certain time limit, and monitor the turnaround time (number of days) for the PIC to make a decision. It is noted that the PIC is not governed by the MAIA Act (2017), however it is an integral part of the Scheme. Thus, this recommendation would be appropriate for the Initial Review of the Rules of the PIC of NSW being undertaken from September 2021 to the first half of 2022.
37	g.3	Recommendation	We recommend the following data be collected and monitored to assess cost-effectiveness of the resolution of disputes: • Cost of insurer internal reviews – average cost per insurer internal review as a proportion of average claim cost for claims that are settled via internal review and do not progress to PIC. • Settlements with or without dispute – costs of settlements for claims with a dispute compared to claims without a dispute. • Cost of escalation - average cost per review as a proportion of average claim cost for claims that escalate to PIC review, considering legal representation.
38	g.4	Recommendation	We recommend that a review is conducted into the types of claims that are suitable for internal review compared to those that should proceed directly to the PIC. Medical disputes relating to whole person impairment appears to be one example where disputes should proceed directly to the PIC. The decision on the types of claims that may be considered suitable or

			optional to the claimant should balance the different Scheme objectives.
39	g.4	Recommendation	Given 43% of IIRs related to weekly benefit amounts are overturned in favour of the claimant, we recommend a review of weekly benefits calculation / processes to reduce the percentage of internal reviews related to the amount of weekly benefits.
40	g.4	Recommendation (CU Recommendation 32 expands on this)	We recommend that SIRA investigate the level of understanding by claimants regarding the scheme and its entitlements, including disputation paths. Taylor Fry's report 'Review of Legal Supports' dated 3 September 2021 recommends a comprehensive survey of claimants would be suitable to achieve this.
41	h	Suggestion	We suggest an exercise to improve the quality, accuracy, and completeness of the UCD is performed to ensure accurate comparisons between insurers and reduce data errors that are not due to insurer errors. Input from insurers will help align data categories between insurers and reduce administrative burden in the future.
42	h	Suggestion	We suggest that SIRA, with stakeholder input, develop a suite of KPIs that will help facilitate the effective management of the Scheme.
43	h	Suggestion	We suggest that SIRA updates the Qlik manual to ensure all conditions and exclusions across each metric are documented and clearly understood. We note that in performing our work, we observed that the majority of metrics on Qlik were appropriately documented.
44	h	Suggestion	We suggest that reconciles and are able to appropriately explain differences from Qlik to other work performed, such as from the Scheme Actuary. This will ensure that the analysis performed by SIRA and other parties do not generate conflicting insights and recommendations.

6. GLOSSARY OF TERMS

Term	Description
1999 Scheme	Previous NSW Compulsory Third Party Insurance Scheme, based on the *Motor Accidents Compensation Act 1999* (NSW)
ACRS	Australasian College of Road Safety
Act	*Motor Accident Injuries Act 2017* (NSW)
AHP	Authorised Health Practitioner
ALA	Australian Lawyers Alliance
AMA	Australian Medical Association
ASIC	Australian Securities and Investments Commission
BAC	Blood alcohol concentration
CTP	Compulsory third party (a common term for the type of insurance that is mandatory under the Act)
Customer Experience and Outcomes Study	Social Research Centre, *SIRA Regulatory Measurement of Customer Experience and Outcomes Study*, November 2020
Deloitte	Deloitte Touche Tohmatsu Pty Ltd
Discussion Paper	Clayton Utz and Deloitte, *Statutory Review of the Motor Accident Injuries Act 2017 - Discussion Paper* (5 July 2021)
DRS	Dispute Resolution Service
Guidelines	Motor Accident Guidelines (Version 7) 2021
ICA	Insurance Council of Australia
icare	Insurance and Care NSW
ILARS	Independent Legal Assistance and Review Service
Indexation Order	Motor Accident Injuries (Indexation) Order 2018 (NSW)
Ipp Review	D Ipp, P Cane, D Sheldon and I Macintosh, *Review of the Law of Negligence: Final Report*, September 2002

IRO	Independent Review Office
JWCRR	John Walsh Centre for Rehabilitation Research
KPI	Key Performance Indicator
LAS	Legal Advisory Service, within CTP Assist
Law and Justice Committee	Parliament of NSW - Standing Committee on Law and Justice
Law and Justice Report	Law and Justice Committee, *2020 Review of the Compulsory Third Party insurance scheme*, Report 77, July 2021
Law and Justice Review	Parliament of NSW - Standing Committee on Law and Justice, 2020 Review of the Compulsory Third Party Insurance Scheme
Legal Support Review	SIRA, Review of Legal Support for Injured People in the NSW CTP Scheme
LTCS Act	*Motor Accidents (Lifetime Care and Support) Act 2006* (NSW)
LTCS Scheme	Lifetime Care and Support Scheme
LTCSA	Lifetime Care and Support Authority
MAITC Benefits Fund	Motor Accident Injuries Treatment and Care Benefits Fund
Minister	Minister for Customer Service
Minor Injury Review	SIRA, *2020 Review of Minor Injury Definition in the NSW CTP Scheme*
NSW	New South Wales
PAWE	Pre-Accident Weekly Earnings
PCA	Prescribed concentration of alcohol
PIC	Personal Injury Commission
PIC Act	*Personal Injury Commission Act 2020* (NSW)
Regulations	*Motor Accident Injuries Regulation 2017* (NSW)
REM	Risk Equalisation Mechanism

REM Deed	Risk Equalisation Mechanism Deed 2017
REM Review	SIRA, *CTP Premium & Market Supervision: Review of the Risk Equalisation Mechanism (REM)*, July 2019
Review	Means Clayton Utz and/or Deloitte, carrying out the statutory review of the *Motor Accident Injuries Act 2017* (NSW)
Scheme or **2017 Scheme**	Current NSW Compulsory Third Party Insurance Scheme, based on the *Motor Accident Injuries Act 2017* (NSW)
SIRA	State Insurance Regulatory Authority
TEPL Guidelines	Motor Accident Guidelines - Transitional Excess Profits and Transitional Excess Losses 2019
WPI	Whole Person Impairment

APPENDIX A: TABLE OF CONTENTS

APPENDIX A: SUMMARY OF SUBMISSIONS

The Discussion Paper posed 89 questions in relation to Scheme design, which were divided by the Act's 8 objectives. The Review received written submissions from 16 interested persons or organisations in response to those questions or to the Terms of Reference generally. The Review also received a request from SIRA to consider certain matters relate to the Scheme.

The Review team attended 13 (virtual) face-to-face consultation meetings with a wide variety of stakeholders, including claimants within the Scheme, insurers, lawyers for claimants and insurers, industry bodies and medical and allied health professionals, among others.

The feedback to the Review is summarised below. The summary also covers relevant submissions to the Law and Justice Review.

The Act's Objectives

The Act's objectives are set out in section 1.3 of the Act:

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.

Objective (a) – Treatment and care

At a general level, the submissions received by the Review agreed that Objective (a) remained valid.[325]

An independent review of 500 of the first claims in the Scheme by the JWCRR concluded that: "*The data show that people injured in motor vehicle crashes are receiving treatment that is generally timely and appropriate. Furthermore, there is no evidence of undertreatment*."[326] A similar review of a different set of 500 claims by the Australian Institute of Health Innovation did not express a view on this point.[327]

In its 2018-19 Annual Report, SIRA stated that, as at 30 June 2019, over 77% of injured people were receiving treatment and care benefit payments within the first three months of their accident, and that this meant "*almost three times as many injured people are receiving the appropriate care within this timeframe as compared with the 1999 Scheme*."[328]

These sources tend to suggest that the Scheme is *capable* of delivering early and appropriate treatment and care to injured persons.

However, the submissions to the Review also indicated that some of the current terms of the Scheme are not appropriate for securing this objective.

In its submission to the Law and Justice Review, the ICA asserted that the Scheme is meeting Objective (a), citing SIRA analyses showing that 74% of injured people access "pre-claim support"[329] which "*enables injured people to self-manage their care and to access treatment and care quickly and easily*."[330] However, in its submission to the Review, the ICA pointed out that CTP Insurers believe legislative amendment could better realise objective (a). It used three examples to illustrate how some claimants' abilities to access treatment and care, optimising their recovery and return to activities, are impeded. Those examples related to the following situations:

- Where an injured person, not at fault, is found not to have a full and satisfactory explanation for a five month delay in lodging their statutory benefit claim. The person would be precluded from making a statutory benefits claim. They would still be able to make a damages claim, however as damages are limited to economic losses associated with loss of earnings and earning capacity, the injured person is unable to obtain financial support for treatment and care.
- Where an injured person, who was mostly at fault in the accident, will have their statutory benefits terminated at 26 weeks. Although they may be entitled to damages, damages will not provide support for treatment and care.
- Where an overseas resident, injured in a NSW motor accident, is unable to recover financial loss associated with treatment and care in their home country.[331]

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[325] See ALA, *Submission to Review*, page 2; Law Society of NSW, *Submission to Review*, page 1; ICA, *Submission to Review*, page 3; Suncorp, *Submission to Review*, page 4; IRO, *Submission to Review*, page 2. A confidential submission expressed the view that Objective (a) does not remain valid.

[326] JWCRR, *Independent File Review of 500 Allocated Insurer Files after the Introduction of the Motor Accident Injuries Act 2017: Final Report*, June 2020, page 30.

[327] Australian Institute of Health Innovation, *Review of the first 1000 claims in the new 2017 CTP Scheme: Final Report*, July 2020.

[328] SIRA, *Annual Report 2018-19*, page 34.

[329] Payable under clauses 4.74 - 4.75 of the Guidelines.

[330] ICA, *Submission to Law and Justice Review*, page 3.

[331] ICA, *Submission to Review*, pages 3 - 4.

The ALA expressed concern over the prolonged nature of some disputes over treatment, asserting that:[332]

> *"Insurers place next to no reliance upon the opinion of treating specialists and place far heavier reliance upon their own at times ill-qualified and so-called independent medico-legal experts. In some instances, insurers cut off treatment in a punitive fashion in relation to what they perceive to be non-compliant conduct by the claimant.*
>
> *The gross delays at the Personal Injury Commission (which delays existed at DRS before the PIC commenced operations and before the pandemic) actively deter claimants from pursuing treatment disputes, as does the need to first clear the hurdle of internal review before obtaining a PIC determination. The ALA has a widely separate tranche of criticisms of the paltry return to work efforts of the CTP insurers. A substantial number of significantly injured claimants never see a rehabilitation plan."*

The ALA also indicated that although SIRA effectively monitors the timeliness of the provision of payments to injured persons, it poorly monitors effectiveness in terms of injured persons returning to work at 12 and 18 months and the related efficacy of insurers' return to work programs.[333]

Dr Chesterfield-Evans stated that some "*insurers have been keen that patients do any 'make work' task that allows them to classified [sic] as 'fit for restricted duties' and thus entitled to less damages. Some employers have been happy to take such workers while their wages were subsidised, with no intention of employing them beyond the subsidised period*."[334]

The Law Society of NSW is concerned that the Scheme "*does not provide the right incentives for all scheme participants to ensure injured people receive appropriate treatment*", and as a consequence, Scheme participants may not receive appropriate treatment. For example, Clause 5.4 of the Guidelines states that diagnostic imaging is not considered necessary to assess minor injuries, effectively denying access to "*useful treatment, as well as [removing] the opportunity to obtain evidence that may show that a non 'minor injury' exists*". Further, the Law Society of NSW points to Clauses 4.74 and 4.75 of Version 7 of the Guidelines, which require all treatment to be approved by an insurer, which may, the Law Society of NSW submits, hinder an injured person from obtaining treatment immediately after the accident.[335]

The Law Society of NSW also noted in its submission that it was aware of anecdotal examples of practices undermining the achievement of objective (a). It notes that some Scheme participants, including medical practitioners, are unaware of the protocols provided by the Act, Regulations and Guidelines, which leads to delay and increased costs.[336]

Dr Arthur Chesterfield-Evans, a treating medical practitioner in the Scheme, asserts that the "financial prism" through which the Scheme is viewed has resulted in "appalling medical results" as "a consequence of the treatments delayed and denied by insurers".[337] He also considers that insurers frequently deny treatments requested by treating medical practitioners, and that some of the aspects of the Scheme allow insurers to act

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[332] ALA, *Submission to Review*, page 2.

[333] ALA, *Submission to Review*, pages 2 - 3.

[334] A Chesterfield-Evans, *Submission to Review*, page 11.

[335] Law Society of NSW, *Submission to Review*, page 1.

[336] Ibid, page 1 - 2.

[337] A Chesterfield-Evans, *Submission to Review*, page 1.

in a way that maximises profits while delaying treatment and worsening outcomes.[338] He considers that "insurers are the chief cause of the failure to deliver timely and appropriate care".[339]

The IRO considers that the Act could include a provision that "the insurer must determine the claim within a specified time frame", on the basis that it has received complaints related to the timeliness of insurer decision-making.[340]

LTCSA considers that as CTP insurers no longer have responsibility for managing long tail claims, "*there is a greater need for SIRA to ensure that CTP insurers remain focussed on achieving health outcomes in the first five years of injury*".[341] There was a concern from LTCSA that some claimants with minor injuries who, if they had received more effective treatment earlier in the claim would no longer require treatment, will be transferred to the Lifetime Scheme after 5 years. This would, the LTCSA asserts, be reflected in an increase in the Fund Levy.[342]

There was a range of responses in relation to suggestions for changes to the Scheme in respect of securing Objective (a). At a high level, suggestions included:[343]

(a) compelling insurers to place greater reliance on treating medical opinion and seek clarification from practitioners where evidence is unclear or incomplete;

(b) addressing the loss of experienced clinical practitioners from the field of medico-legal opinion providers;[344]

(c) streamlining timelines for treatment disputes to ensure prompt treatment;

(d) streamlining dispute processes so the PIC can produce a treatment dispute or minor injury dispute decision in less than 6 months;

(e) ensuring insurers meet their obligations by advising claimants of their paid care entitlements;

(f) ensuring insurers meet their obligations by developing rehabilitation plans;

(g) enabling injured people with ongoing entitlements to weekly benefits or damages to access the treatment, rehabilitation and care they require to optimise their recovery;

(h) removing clause 5.4 of the Guidelines, offsetting any additional costs by limiting the cost of diagnostic imaging; and

(i) improving access to early treatment before a claim is made, without requiring approval by an insurer. This may include imposing a financial limit (for example, $2,500) for certain types of treatment prior to 28 days.

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[338] Ibid, *Submission to Review*, page 6.

[339] Ibid, *Submission to Review*, page 8.

[340] IRO, *Submission to Review*, page 2.

[341] LTCSA, *Supplementary Submission to Review*, page 3.

[342] LTCSA, Consultation Meeting.

[343] See ALA, *Submission to Review*, page 3; ICA, *Submission to Review*, page 4; Law Society of NSW, *Submission to Review*, page 2.

[344] In its submission, Suncorp noted that "*appropriate treatment and care is coordinated and managed directly by the treating doctor. As an insurer, we are guided by the treating doctor's recommendation and where necessary, a Recovery Plan can be created to assist with the optimum recovery of a person's injury. As the Scheme is non-adversarial, we have moved away from reliance of medico-legal assessment in order to determine appropriateness of treatment and care*": Suncorp, *Submission to Review*, page 4.

In a consultation meeting with the ALA, the rationale for recommendation (a) above was expanded upon.[345] The ALA made comment that there are 4 issues that feed into the recommendation, being:

1. some treating practitioners refuse to treat people in the Scheme, as a result of perceived bureaucratic burdens and a lower level of financial incentive;
2. some treating practitioners do not set out information in reports in the way insurers would have them do it. Some specialist doctors do not have the time nor the inclination to be writing detailed reports;
3. insurers have not given primacy to doctors as was envisaged under the Scheme; and
4. poor enforcement by SIRA in terms of insurers ignoring treating medical opinion.

In relation to treating practitioners, there were some comments in the medical and allied health consultation meeting that minor omissions when filling out forms for requests for treatment will result in a "back and forth" with the insurer, delaying treatment for "a month or two". Similarly, an opinion was expressed that some practitioners refuse to treat people in the Scheme because of the paperwork required, meaning some of the best practitioners are deterred from the Scheme. There was also a comment that psychiatrists avoid doing work in the Scheme, as in the practitioner's experience it is difficult to get approval, and approval is limited by insurers to 2 sessions.[346]

There was also a concern held by the Law Society of NSW about the direct relationship between the insurers and the rehabilitation providers on their panels, which may cause unease for some claimants.[347] This concern was echoed by Dr Chesterfield-Evans, who considered that rehabilitation coordinators should be chosen by patients, in consultation with their doctors.[348]

Recommendation (i) above was echoed in part by the IRO's submission, which considered that, similar to the NSW Workers Compensation Scheme, there could be a number of treatments "where CTP insurer approval is not required".[349] However, a representative from the IRO, speaking in their personal capacity considered that a list of treatment categories, rather than a financial amount, should be given.[350]

As to the appropriateness of care received by claimants under the Scheme, and its facilitation of return to a claimant's usual activities, the submissions were mixed. The ALA and the Law Society of NSW indicated that the treatment and care received by claimants was not always appropriate, and that claimants are not always adequately supported in their return to activities.[351]

In comparison, the ICA and Suncorp were of the view that claimants are generally provided with appropriate treatment and care, directed towards a return to work and other activities, underpinned by Scheme design features such as claimants' opportunities to be assessed by occupational therapists, the principle of early intervention, claimants being screened for being at risk of poor recovery, the development of rehabilitation plans, and the monitoring of treatment effectiveness.[352]

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[345] ALA, Consultation Meeting.

[346] Medical and Allied Health, Consultation Meeting.

[347] Law Society of NSW, Consultation Meeting.

[348] A Chesterfield-Evans, *Submission to Review*, page 5.

[349] IRO, *Submission to Review*, page 3.

[350] IRO, Consultation Meeting.

[351] ALA, *Submission to Review*, page 3; Law Society of NSW, *Submission to Review*, pages 2 - 3.

[352] ICA, *Submission to Review*, page 4; Suncorp, *Submission to Review*, page 4.

There was general consensus on the issue of whether the determination of the relevant insurer after a motor accident affects policyholders by delaying receipt of statutory benefits, and whether that process works effectively from the perspective of the injured person. The ALA, Law Society of NSW, the ICA and Suncorp all expressed that, at least for the most part, sections 3.2 and 3.3 of the Act have worked well, and stakeholders are largely satisfied with the process and timeliness of relevant insurer determinations.[353]

In relation to paid attendant care for injured persons under section 3.25 of the Act, the ICA and Suncorp are of the view that this care is readily available to injured people.[354] The ICA considers that this provision advances "multiple objects" in the scheme and does not undermine the scheme objects,[355] while Suncorp specifically pointed to the deterrence of fraud as an outcome of this provision.[356] The ALA and the Law Society of NSW contend that greater oversight of this process is required to ensure that insurers offer, and deliver, the benefits that are costed in premiums.[357] These stakeholders consider that claimants should have the right to "*have close friends or family perform paid care on their behalf in circumstances where they elect for that to occur rather than the provision of commercial care services arranged by the insurer*", however the ALA notes that this is not its first priority for additional expenditure.[358] LTCSA considers that LTCSA has not encountered issues in finding and providing paid care support for injured persons, and note that the development of the NDIS has seen this sector expand.[359]

Two of the principal changes from the 1999 Scheme to the current Scheme were the introduction of a 6 month period of statutory benefits for (almost) all injured persons regardless of fault, and the limited entitlements of persons with "minor injuries" only. Statutory benefits for treatment and care (and weekly payments) after 6 months are not available to persons suffering minor injuries only or to persons who were most at fault in the accident.[360] Stakeholders' views on these issues are considered in separate sections below.

Objective (b) – Financial support

Objective (b) is "to provide early and ongoing financial support for persons injured in motor accidents". This Objective – along with Objectives (a) and (g) – is directed primarily towards the outcomes of the Scheme for claimants, as opposed to the later Objectives that are directed towards insurers, users of motor vehicles in NSW and the Scheme more generally.

Together with Objective (a), Objective (b) makes it clear that the focus of the Scheme is intended to be on post-accident financial support and recovery from injury, and not on monetary compensation for loss.

The statutory entitlement to weekly benefits rather than reliance on claiming damages for lost earnings is itself intended to facilitate early financial support, and makes that support available to at-fault injured persons as well.

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[353] See ALA, *Submission to Review*, pages 3 - 4; ICA, *Submission to Review*, page 4; Law Society of NSW, *Submission to Review*, pages 2 - 3, Suncorp, *Submission to Review*, pages 4 - 5.

[354] ICA, *Submission to Review*, page 5; Suncorp, *Submission to Review*, page 5.

[355] ICA, *Submission to Review*, page 5.

[356] Suncorp, *Submission to Review*, page 5.

[357] ALA, *Submission to Review*, page 4; Law Society of NSW, *Submission to Review*, page 3.

[358] ALA, *Submission to Review*, page 4; Law Society of NSW, *Submission to Review*, pages 3 - 4.

[359] LTCSA, *Submission to Review*, page 3.

[360] Section 3.28 of the Act.

Objective (b) contains two parts: to provide "early" and "ongoing" financial support. The "ongoing" nature of the financial support is time-limited for all injured persons and more strongly limited for persons with only minor injuries and injured persons who are at fault or whose negligence contributed to the accident.

The ALA, the ICA, Suncorp, the IRO and the Law Society of NSW agree that this objective remains valid.[361] A confidential submission considers that the objective requires "improvement and simplification".[362]

In relation to the terms of the Scheme directed to the achievement of Objective (b), the ICA is of the view that they remain appropriate.

However, the ALA considers that the "inflexible" 28 day timeframe a claimant has in which to lodge a claim is unduly harsh.[363] The Law Society of NSW agrees, and considers it is oppressive to some claimants, resulting in unjust outcomes. It suggests:[364]

- "*a mechanism for discretion be available for the insurer to accept a claim beyond the 28-day timeframe and to backpay wages*"; and
- "*where this is refused, the PIC should be given jurisdiction to order a back-payment of wages where the claimant has a full and satisfactory explanation for the delay in lodging*" the claim form.

A stakeholder contends that there are 5 issues that affect the achievement of this objective, being:[365]

(a) "*The complexity surrounding the entitlement to weekly statutory benefits – including the legislative thresholds and entitlement periods, and the subsequent creation of multiple avenues of dispute as a result of the complexity.*

(b) *The delays caused by the Personal Injury Commission (PIC), and in particular the delays caused by the introduction of the 'wholly or mostly' at fault thresholds.*

(c) *The verification difficulties, when it comes to calculation of pre-accident weekly earnings ('PAWE') - including lack of detail required in completing the requisite claim forms, and the delay in the requirements to provide particulars.*

(d) *The impact of the statutory scheme and entitlements, on the ultimate assessment of damages.*

(e) *The barriers in place to prevent the early lodgement of damages claims.*"

That stakeholder considers that these issues are not able, at least on the data currently collated by SIRA, to be documented in quantitative terms. However, that stakeholder points to the number of disputes before the PIC regarding the "wholly or mostly" at fault threshold, and the length of time they take to resolve.[366]

The stakeholder also considers the "inundation of applications for assessment of the damages claims" that are lodged at 3 years post-accident, but are often not ready to proceed.[367]

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[361] ALA, *Submission to Review*, page 7; ICA, Submission to Review, page 8; Suncorp, *Submission to Review*, page 6; IRO, *Submission to Review*, page 4; Law Society of NSW, *Submission to Review*, page 7. A confidential submission expressed the view that Objective (b) does not remain valid.

[362] *A confidential submission*.

[363] ALA, *Submission to Review*, page 7.

[364] Law Society of NSW, *Submission to Review*, page 8.

[365] *A confidential submission*.

[366] Ibid.

[367] Ibid.

In relation to these issues, the stakeholder proposes the following:[368]

(a) "*An overhaul of the current statutory payment periods, and threshold tests*

(b) *Changes to the timeframes regarding the lodgement of a damages claim, and material provided at lodgement*

(c) *Legislative requirements to provide evidence of earnings, to assist in the calculation of PAWE*

(d) *Changes to the ability to qualify medico-legal evidence*"

In terms of evidence going to whether the Scheme is achieving this objective, SIRA's most recent *CTP Insurer Claims Experience and Customer Feedback Comparison* provides insight. 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.[369] 1% of claimants waited between 6 months and a year to receive weekly payments.[370] 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.[371]

The ICA uses SIRA's data above to point to claimants' earlier access to financial support than under the previous Scheme.[372] However, it also considers that if it is financially viable for the Scheme, extending the 26 week statutory benefit period for at-fault road users with a non-minor injury may better achieve Objective (b).[373]

Pre-accident weekly earnings

The determination of a person's PAWE is critical in calculating the rate of the person's weekly statutory benefit payment.

Where a person's PAWE cannot be determined in the first 13 weeks of a claim, "interim" payments are available. The IRO observes there are sometimes delays in providing this early financial support, and considers that there should be provisions equivalent to those in workers compensation "*that ensure timely payments of compensation to most workers immediately after an injury, and while insurers are determining a claim*".[374]

The Law Society of NSW (with the ALA's support[375]) submits that in practice, the calculation of PAWE "*has become one of the most complex issues in the scheme.*"[376] It cites recent disputes to illustrate the complexity of this calculation, which it and the ALA contend is often a miscalculation.[377] It considers that insurers often

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[368] Ibid.

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

[370] Ibid.

[371] SIRA, *Submission to Law and Justice Review*, page 15.

[372] ICA, *Submission to Review*, page 8.

[373] Ibid.

[374] IRO, *Submission to Review*, page 5.

[375] ALA, *Submission to Review*, page 7.

[376] Law Society of NSW, *Submission to Review*, page 8; Law Society of NSW, *Submission to Law and Justice Review*, page 10.

[377] ALA, *Submission to Review*, page 7; Law Society of NSW, *Submission to Review*, pages 8 - 9.

engage forensic accountants to conduct these calculations, while claimants may "*not have the means or know how to instruct a forensic accountant to counter the insurer's forensic accountant report*."[378] The Law Society of NSW considers that legal fees should be allowed for assistance with PAWE and weekly payment disputes, and that either a directory of PAWE determinations should be accessible, or numeric formulae should be added to the Act.[379] The Law Society of NSW also considers that the effect of the COVID-19 pandemic has been to artificially reduce some incomes, which leads to problems when calculating PAWE.[380]

The Law Society of NSW highlights that "at least one insurer … has had significant issues relating to the calculation and payment of PAWE", however SIRA's regulatory determinations are not publicly available. It submits that they should be published in a "central, easily accessible place", to enhance Scheme transparency and promote better claimant outcomes.[381]

The ICA considers that the provisions generally work to achieve the Objective, relying on "amount of weekly payments" being the least disputed internal review category.[382] However, the ICA notes that the provisions could be simplified to aid "claimant and insurer understanding, decision making and claimant experience."[383] It notes that some work arrangements of claimants, such as those who are self-employed, "challenge the statutory framework for the calculation of weekly benefits".[384]

Suncorp is satisfied that these provisions work as intended by the legislation, and welcomes SIRA's proposed amendments in relation to "post-accident earnings", the permanence of loss of earning capacity, and shorter interval payments for overseas residents.[385] However, it also considers that the definition of PAWE is unfavourable for self-employed claimants with fixed deductions and should be reviewed to avoid disadvantaging these persons.

A stakeholder noted that there are a number of difficulties encountered by insurers, summarised as:[386]

(a) "*Obtaining accurate and complete evidence of pre-accident earnings*

(b) *Significant vagaries in the requirements to determine 'capacity' post 78 weeks*

(c) *Barriers to obtaining medico-legal evidence, which would assist in determining capacity*"

The stakeholder provided detailed submissions as to possible amendments, including that the current system of payments be simplified by creating a single payment period rather than the 3 that exist under the current Scheme.

In relation to the 2 year limit on weekly payments unless there is a pending claim for damages, Suncorp considers the current Scheme works well.[387] The ICA agrees, stating that the "*current requirement for a*

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[378] Law Society of NSW, *Submission to Review*, page 9.

[379] Law Society of NSW, *Submission to Law and Justice Review*, page 10; Law Society of NSW, *Submission to Review*, page 9.

[380] Law Society of NSW, Consultation Meeting.

[381] Law Society of NSW, *Submission to Review*, page 9.

[382] ICA, *Submission to Review*, page 9.

[383] Ibid.

[384] Ibid.

[385] Suncorp, *Submission to Review*, page 6.

[386] *A confidential submission*.

[387] Suncorp, *Submission to Review*, page 7.

damages claim to be made in order to continue to receive weekly benefits is important as it ensures those weekly benefit claims that have remained in the Scheme are those with more serious injuries".[388]

However, the ALA and the Law Society of NSW both contend that weekly payments should continue if there is a dispute presently before the PIC as to the extent of the claimant's injuries.[389]

A confidential submission considers that the preferable position would be to have a set period for the provision of statutory benefits available to all claimants, including by removing the "wholly or mostly at fault" threshold.[390]

Where no one is at fault, the ALA considers that it is appropriate to "cut off" wages at 2 years,[391] however the Law Society of NSW considers that if there is a dispute before the PIC, the person should remain entitled to weekly payments.[392]

The ICA considers that drivers in no-fault single-vehicle accidents should be provided with statutory benefits on the same basis as drivers considered wholly or mostly at fault.[393]

Paid and gratuitous care

The Act provides that there are no statutory benefits payable for gratuitous attendant care services.[394] Depending on the local availability of required attendant care services, this is likely to increase the risk of financial hardship to the households of at least some injured persons. To this extent, the exclusion of statutory benefits for gratuitous attendant care has the potential to cut across Objective (b). Carers NSW, in a submission to the Law and Justice Review, considered that the Scheme could provide for "*medical costs, economic loss and non-economic loss*" experienced by carers of injured people.[395] In a consultation meeting with the Law Society of NSW, some members expressed their views, as we understood them, that commercial care may not take into account the claimant's gender, cultural background, or age, which may affect the quality of care the claimant receives.[396]

The ALA considers that premium dollars would be better spent elsewhere.[397] However, the ALA (and the Law Society of NSW) in consultation meetings, also expressed the view that insurers are not appropriately advising claimants on the opportunity to take up paid care under the Scheme.[398] A confidential submission also considers that commercial care services are best placed to provide care, as they can be monitored and

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[388] ICA, *Submission to Review*, page 10.

[389] ALA, *Submission to Review*, pages 7 - 8; Law Society of NSW, *Submission to Review*, pages 9 - 10.

[390] *A confidential submission*.

[391] ALA, *Submission to Review*, page 8.

[392] Law Society of NSW, *Submission to Review*, page 10.

[393] ICA, *Submission to Review*, page 11.

[394] Section 3.25 of the Act.

[395] Carers NSW, *Submission to Law and Justice Review*, page 2.

[396] Law Society of NSW, Consultation Meeting.

[397] ALA, *Submission to Review*, page 8.

[398] ALA, Consultation Meeting; Law Society of NSW, Consultation Meeting.

reviewed.[399] LTCSA, in the context of a lifetime scheme, considers there are disadvantages to having a family member provide this care.[400]

20 month waiting period for claim for damages

SIRA expresses the view that the 20 month waiting period for injured people with less than 10% permanent impairment provides time for maximum recovery before lodging a claim for damages, but agrees that the statutory review provides an opportunity to consider whether this aspect of the Scheme should be changed.[401]

The Law Society of NSW and a confidential submission do not consider that injured persons with non-minor injuries should have to wait 20 months to claim damages.[402] The Law Society of NSW has previously stated that the 20 month waiting period "*is an unnecessary friction point in the Scheme.*"[403]

The ALA also considers that the 20 month waiting period should be abolished.[404] It considers that the real purpose of this requirement is to encourage injured persons to leave the Scheme without claiming damages at all.[405] The ALA considers that the 20 month waiting period essentially only serves to build delay into the Scheme for persons with less than 10% permanent impairment.

The ICA acknowledges the rationale for the 20 month delay. However, it also considers that it creates friction, and therefore recommends:[406]

> "*that most injured people should not be required to wait 20 months to lodge a claim for damages, nor should they be required to wait to settle their claim if they have sufficiently recovered for the purposes of quantifying their claims (that is maximum medical improvement has been reached).*
>
> *Insurers think there is merit in considering a flexible approach to the time within which a damages claim can be lodged and settled for these claimants.*
>
> *Insurers consider the waiting period should be reduced from 20 months to a time that better reflects recovery.*
>
> *Insurers' recommendation would be to consider changing the requirement to allowing the reporting of damages claims to anytime following the formal decision on minor injury and fault i.e. once the decision is made to accept a claim as not (or mostly) at fault/non-minor either made by the insurer or following internal review and/or PIC decisions. We also recommend the removal of any time restriction on settlement of claims considering insurers are required to wait until after maximum medical improvement has been reached before a settlement can occur in any case*."

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[399] *A confidential submission*.

[400] LTCSA, *Submission to Review*, page 4.

[401] SIRA, *Standing Committee on Law and Justice 2020 Review of the Compulsory Third Party Insurance Scheme: Pre-hearing questions for SIRA*, pages 7, 8.

[402] Law Society of NSW, *Submission to Review*, page 8; *a confidential submission*.

[403] Law Society of NSW, *Submission to Review*, page 11.

[404] ALA, *Submission to Law and Justice Review*, page 41.

[405] Ibid; Law and Justice Review, *Hearing Transcript*, 25 May 2021, page 38 (Mr Stone).

[406] ICA, *Submission to Review*, page 12.

All submissions received on this point agreed that the 20 month period does not align with the Act's objects, particularly Objective (g).[407] Similarly, subject to one qualification, all submissions on the point agreed that the 20 month period does not encourage the early resolution of claims, does not deter injured persons from making damages claims, and does not effectively deter fraud.[408] The one qualification to that is that the Law Society of NSW considers that "many injured persons become frustrated and abandon their entitlements, even with legal assistance".[409]

All relevant submissions agreed that the 20 month period does not benefit injured persons, as it leads to delay.[410] All relevant submissions, except the one received from the ALA, agreed that it does not benefit insurers.[411] The ALA considered that insurers "profit when claimants abandon their entitlements because they are forced to wait to collect them".[412] The Law Society of NSW and the ICA consider that the 20 month period does not have a positive effect on policyholders by having a material effect on premiums, and may in fact have a negative effect.[413]

As noted above, the rationale for the 20 month period is to allow maximum recovery from injury before damages are claimed. No submissions were received in support of this rationale's application to claimants only with WPI <10%.[414]

In terms of removing or reducing the 20 month period, the ICA and the Law Society of NSW consider that section 6.23(1) of the Act, relating to the 2 year prohibition on settling claims, would also need to be removed or reduced.[415] A confidential submission considered that other changes to the Act would be contingent on other amendments made, however suggest that the timeframes in sections 3.12 and 6.26 of the Act may need to be considered.[416] The ALA suggests[417]

> "*bringing forward the period for notifying damages claims to a window of 6 to 12 months post-accident with a mandatory obligation for insurers to send claimants a damages claim form at 6 months and again at 9 months with information as to how damages entitlements are to be pursued*."

In terms of the assessment of damages, a confidential submission to the Review outlined that the 5% discount applied to compensation should be examined "*to reflect reasonable expectations on claimants and*

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[407] ALA, *Submission to Review*, page 8; *a confidential submission*; ICA, *Submission to Review*, page 12; Law Society of NSW, *Submission to Review*, page 11.

[408] ALA, *Submission to Review*, page 9; *a confidential submission*; ICA, *Submission to Review*, pages 12 - 13; Law Society of NSW, *Submission to Review*, page 11.

[409] Law Society of NSW, *Submission to Review*, page 11.

[410] ALA, *Submission to Review*, page 9; *a confidential submission*; ICA, *Submission to Review*, page 13; Law Society of NSW, *Submission to Review*, page 12.

[411] *A confidential submission*; ICA, *Submission to Review*, page 13; Law Society of NSW, *Submission to Review*, page 12.

[412] ALA, *Submission to Review*, page 9.

[413] ICA, *Submission to Review*, page 13; Law Society of NSW, *Submission to Review*, page 12.

[414] See ALA, *Submission to Review*, page 9; *a confidential submission*; ICA, *Submission to Review*, page 13; Law Society of NSW, *Submission to Review*, page 12.

[415] ICA, *Submission to Review*, page 13; Law Society of NSW, *Submission to Review*, page 13.

[416] *A confidential submission*.

[417] ALA, *Submission to Review*, page 9.

current economic conditions … Consumers should not be expected to undertake risky investments on the chance they can be adequately compensated into the future."

Further, the cap on weekly statutory benefits and compensation for non-economic loss are considered "unfair" and "inadequate", particularly in the context of a person who has lost a family member or partner. The Road Trauma Support Group NSW recommends that these caps be reviewed.[418]

Objective (c) – Compulsory CTP insurance

Objective (c) did not attract much feedback. The Act makes CTP insurance compulsory in NSW and this secures Objective (c).

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.*"[419]

All submissions received by the Review were of the view that this objective remains valid, and that the terms of the Scheme are appropriate for achieving it.[420]

Objective (d) – Affordability

The validity of this objective received some disagreement among the submissions to the Review.

The ALA considers that the objective remains valid "in a relative rather than an absolute sense".421 The Law Society of NSW also supports maintaining premium at an affordable level, however not at the expense of priorities such as fairness and accessibility to dispute pathways.422

Suncorp considers this objective remains valid.423 The ICA considers that the objective is valid, and that keeping premiums affordable ensures road use is readily available to all.424 The ACRS considers that "Safety should always take *priority over profit, so premiums must be kept to an affordable level and incentivise younger drivers towards newer, safer vehicles.*"[425]

Dr Tooth has a number of concerns with the objective. They can be summarised as follows:426

> *"The objective specifies a vague outcome. As discussed earlier, there is no objective definition of affordability.*
>
> *The objective is limited in how the outcome is to be obtained. There are other means to improve affordability …*

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[418] Road Trauma Support Group NSW, Consultation Meeting.

[419] SIRA, *Submission to Law and Justice Review*, page 15.

[420] ALA, *Submission to Review*, page 9; Law Society of NSW, *Submission to Review*, page 13; ICA, *Submission to Review*, page 14; R Tooth, *Submission to Review*, page 11; Suncorp, *Submission to Review*, page 8.

[421] ALA, *Submission to Review*, page 10.

[422] Law Society of NSW, *Submission to Review*, page 13.

[423] Suncorp, *Submission to Review*, page 8.

[424] ICA, *Submission to Review*, page 15.

[425] ACRS, *Submission to Review*, page 8.

[426] R Tooth, *Submission to Review,* page 12.

The methods to achieve affordability are poorly described and do not reflect the underlying issues.

There does not seem to be a need for an ongoing objective and regulation pertaining to insurer profits."

In terms of securing this objective through the terms of the Scheme, the ALA predicts that insurers will post "super profits" from the opening years of the Scheme.[427] It also considers that the "extent to which SIRA can or is willing to try and claw back those super profits remains to be seen".[428]

The ICA states that premiums have decreased since the inception of the Scheme and are trending downwards, using this to indicate that the Act, Regulations and Guidelines are working to secure Objective (d).[429] The Law Society of NSW notes that "premiums are being kept at extremely affordable levels", against any measure of affordability.[430]

Dr Tooth has concerns with the way this objective has been interpreted through the terms of the Scheme. He considers that interpreting the objective in a way that requires cross-subsidies between low and high risk drivers:[431]

- "*has not been justified or tested through public consultation*
- *has perverse implications – in effect, it involves subsidising high-risk activity*
- *has significant adverse consequences for road-safety, scheme complexity, and average premiums*."

He also references international research findings that stringent rate regulation leads to worse outcomes, including higher premiums.[432]

In terms of changes to the Scheme to secure this objective more effectively, the ALA expresses concern about the "profit claw back provisions" and the way the innovation mechanism may be "conducted entirely in secret and with no external or stakeholder scrutiny".[433] However, Dr Tooth expects "the profit measures are no longer required and are counterproductive".[434]

The ICA supports the innovation support framework, however considers the process could be simplified,[435] for example by allowing pilot programs without SIRA's pre-approval.[436] Suncorp supports such simplification, labelling the current process "lengthy, complex and inflexible".[437] The ICA also suggests an annual expense

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[427] ALA, *Submission to Review*, page 10.

[428] Ibid.

[429] ICA, *Submission to Review*, page 15.

[430] Law Society of NSW, *Submission to Review*, page 13.

[431] R Tooth, *Submission to Review*, page 1.

[432] Ibid, page 4.

[433] ALA, *Submission to Review*, page 11.

[434] R Tooth, *Submission to Review*, page 13.

[435] ICA, *Submission to Review*, page 15.

[436] ICA, Consultation Meeting.

[437] Suncorp, *Submission to Review*, page 8.

review should be undertaken by a SIRA-driven governance process to assess insurer expenses against increased requirements in the Scheme.[438]
The Law Society of NSW observes that the "*more friction points within any third-party system, the greater the risk of the Scheme becoming less affordable*", and on this basis questions whether there should be over 50 areas of potential dispute within the Scheme.[439]

The regulation of insurer profits and the limitation of benefits for persons with minor injuries are specifically identified in Objective (d) as means of keeping premiums affordable. When asked to consider whether other means of keeping premiums affordable should be considered, the submissions were mixed.

The ICA considers that as the objective is currently being met, there is no need to expand it to introduce other means of ensuring affordability. Doing so, the ICA and Suncorp contend, would add to complexity and cost in the Scheme, which could affect competition and future premiums.[440] However, the ICA is also of the view that "*the objective would benefit from including a reference to the intended limitations on access to damages*".[441]

Dr Tooth questions the adoption of the policy of cross-subsidisation, particularly as it relates to notions of affordability, which he contends has no objective definition. To that end, he recommends that the average cost of premiums could be reduced by providing insurers with "flexibility and incentive to reduce the frequency and severity of road crashes" and "reduce the regulatory burden".[442]

The Law Society of NSW considers that "*If the limitation on benefits for "minor injuries" was intended to keep premiums affordable, then the Law Society submits that the minor injury test has gone too far*." On the basis that as a result of a minor injury determination, "*claimants have been deprived of the right to any ongoing statutory benefits beyond 26 weeks and they have been deprived of the right which would otherwise have been available to them to pursue a damages claim for their injuries*", it recommends amendments to the minor injury definition.[443]

Premium regulation

The key element of the premium regulation framework for securing Objective (d) is the provision in clause 1.59 of the Guidelines setting a maximum of 8% for the profit margin assumption input into filed premiums.

SIRA has indicated that insurer premium filings "*have included prospective profit margins at or below the benchmark of 8 per cent profit*."[444]

To the extent that the profit assumption in filed premiums turns out to be less than the realised profit, SIRA has powers under the Act to reduce the size of the realised profit.

In terms of this 8% profit margin, the ICA is of the view that it does not exceed the amount of profit that is sufficient to underwrite the risk, however considers that a review into whether 8% is appropriate in light of

[438] ICA, *Submission to Review*, page 15.

[439] Law Society of NSW, *Submission to Review*, page 14.

[440] ICA, *Submission to Review*, page 16; Suncorp, *Submission to Review*, page 9.

[441] ICA, *Submission to Review*, page 16.

[442] R Tooth, *Submission to Review*, page 13.

[443] Law Society of NSW, *Submission to Review*, page 14.

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

capital requirements could be undertaken.[445] Suncorp considers 8% is an adequate margin in light of the APRA capital requirements.[446]

Risk equalisation

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*".[447] The review also concluded that insurers "*have expressed general satisfaction with the existence of the REM and its overall design*."[448]

An important point in the overall conclusions of the REM Review in relation to cross-subsidisation was that: "*Excessive profits are no longer available to any individual insurer and, in particular, new vehicles formerly generated high profits, but the REM has put an end to this opportunity*."[449]

Profit regulation

Transitional Excess Profit and Loss

In the TEPL analyses undertaken in 2020, there were insufficient claims for the 2018 Accident Year (the first Accident Year of the Scheme) and SIRA deferred any decision as to whether to activate TEPL to recover excess profit. SIRA is currently awaiting actuarial advice as to whether to trigger the next steps in the TEPL process for the 2018 and 2019 accident years.[450]

The ICA and Suncorp consider that as the TEPL mechanism has not yet been fully enacted, it is too early to identify aspects of it that may not align with Objective (d).[451]

In recent submissions by some stakeholders to the Law and Justice Review, concerns were expressed that some assumptions used to calculate premiums during the transition period (i.e. the early years of the Scheme) have proved to be wrong, and that excessive profits would be the result.[452] If those concerns are correct, then it follows that there will be occasion for SIRA to consider activating the TEPL mechanism to recover excess profit in accordance with the relevant provisions of the Act and the TEPL Guidelines. The Review's understanding is that this is the scenario for which the TEPL provisions in Part 2 of Schedule 4 of the Act were originally enacted.[453]

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[445] ICA, *Submission to Review*, page 16.

[446] Suncorp, *Submission to Review*, page 9.

[447] SIRA, *REM Review*, page 12.

[448] Ibid, page 3.

[449] SIRA, *REM Review*, page 4.

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

[451] ICA, *Submission to Review*, page 16; Suncorp, *Submission to Review*, page 9.

[452] See, for example: ALA, *Submission to Law and Justice Review*, page 7.

[453] As originally enacted, the provisions in Part 2 of Schedule 4 to the Act directed to excess profits were specifically drafted to address profits derived from underestimation of the reduction in cost of claims to result from the new Scheme. The provisions were subsequently amended to give the TEPL profit regulation mechanism a broader scope of operation to address excess profits generally, and not only those that derive from underestimation of the cost of claims to result from the new Scheme.

Some concerns were also expressed that only a small percentage of premium receipts have been expended by way of claim payments in the Scheme to date.[454] The Motorcycle Council of NSW is concerned that TEPL only examines insurers' profits as a whole, meaning that it cannot be guaranteed that insurers do not make super profits specifically from motorcycle policies.[455]

The ALA has stated that although a clawback mechanism for insurer super profits has been introduced by way of the TEPL Guidelines, the mechanism's efficiency is "*as yet untested*". The ALA is concerned about "*the shortage of any serious evaluation from SIRA analysing any early trends.*"[456] It also considers that the innovation mechanism will operate as an "escape hatch".[457]

Dr Tooth considers that rate regulation lead to adverse outcomes, and that this thesis is applicable to the TEPL mechanism.[458]

The ICA and Suncorp are also concerned that the activation of the TEPL mechanism should not result in premium volatility.[459]

In response to a suggestion that excess profits collected by insurers could be used to fund road-related initiatives rather than being used to fund reductions in the cost of CTP insurance, there was general agreement most stakeholders, for various reasons, that such an approach would not be likely be aligned with Objective (d).[460] However, one stakeholder did consider that returning a portion of profits to road safety initiatives such as care and support programs, educational resources and the expansion of the use of telematics data and technology innovation would advance Objective (d).[461]

Section 2.25 (profit regulation after the transition period)

There are some ways in which the mechanism under section 2.25 will be different from the TEPL mechanism. For example, the reference points for assessment and adjustment of insurer profit under section 2.25 are insurers' filed profits, both on average and taken individually. Under TEPL, the reference is not a point and does not depend on the assumptions built into insurers' premium filings – the reference is the range of profit that SIRA determines to be reasonable.

Another difference is that, while Part 2 of Schedule 4 of the Act contemplates that SIRA may take steps to "avoid or minimise" excess profits, adjustments under section 2.25 must "avoid" excess profits. This means that if the section 2.25 mechanism is activated in respect of excess profit then insurers' profit margins must be brought down to the filed profit margin – SIRA would not appear to have any flexibility to reduce insurer profits by a lesser amount. This arguably also applies to upward adjustments to insurer profits, so that if SIRA decides to adjust profits upwards because they are found to be too low, then they must be adjusted all the way up to the filed profit margin and not by any lesser amount.

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[454] See, for example NSW Bar Association, *Submission to Law and Justice Review*, page 12.

[455] Motorcycle Council of NSW, *Submission to Review*, page 3; Motorcycle Council of NSW, *Submission to Law and Justice Review*, page 3.

[456] ALA, *Submission to Law and Justice Review*, page 5.

[457] ALA, *Submission to Review*, page 11.

[458] R Tooth, *Submission to Review*, page 14.

[459] ICA, *Submission to Review*, page 16; Suncorp, *Submission to Review*, page 9.

[460] ALA, *Submission to Review*, page 11; Law Society of NSW, *Submission to Review*, pages 14 - 15; R Tooth, *Submission to Review*, page 14; ICA, *Submission to Review*, page 17; Suncorp, *Submission to Review*, page 9.

[461] Road Trauma Support Group NSW, Consultation Meeting.

The ICA and Suncorp both support the closer alignment of section 2.25 of the Act with Part 2 of Schedule 4 of the Act.[462]

Objective (e) – Premium setting and SIRA's role

Although the Law Society of NSW, Suncorp and the ALA considered that Objective (e) remains valid,[463] there was some concern among the ICA and Dr Tooth on parts of the objective.[464]

While Dr Tooth considers that promoting competition and innovation is a valid objective, he is concerned about the requirement of the clause "in the setting of premiums for third-party policies". He suggests that a more general clause would be appropriate, such as "in the pricing and supply of third-party insurance". He contends that this would "reflect the broader role of insurers in managing accident risk".[465] The ICA considers that this objective could be revised to promote competition and innovation in more areas, not just premium setting. It suggests that pricing regulation, risk equalisation and the TEPL mechanism place "*considerable constraint upon competition in premium setting and limit the benefits that can flow to motorists*",[466] and on this basis competition and innovation should be promoted in a broader sense.

Both Dr Tooth and the ICA take issue with the second part of the objective, being "to provide the Authority with a role to ensure sustainability". The ICA does not believe this part is necessary, [467] and Dr Tooth considers that it is APRA's responsibility to prudentially monitor general insurers, and SIRA's role to support APRA in this function.[468]

Stakeholders' views on the appropriateness of the terms of the Scheme in delivering Objective (e) are not uniform among the submissions. The ICA considers that the terms are appropriate, using the 28% reduction in premiums to "suggest that the current regulatory mechanisms are promoting competition", and that insurers compete to the "extent permissible" under the Scheme.[469] It suggests that while there is "some competition on price", there is scope to realise "the benefits of innovation and competition in the Scheme".[470] However, the Law Society of NSW does not believe SIRA has yet explored "its full powers of regulatory compliance with insurers to date".[471]

SIRA asserts that there is competition in the NSW CTP market putting downward pressure on premium prices.[472] Suncorp's view is that since the inception of the Scheme, insurers have increasingly competed on

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[462] ICA, *Submission to Review*, page 17; Suncorp, *Submission to Review*, page 9.

[463] Law Society of NSW, *Submission to Review*, page 15; Suncorp, *Submission to Review*, pages 9 - 10; ALA, *Submission to Review*, page 12.

[464] ICA, *Submission to Review*, page 18; R Tooth, *Submission to Review*, pages 14 - 15.

[465] R Tooth, *Submission to Review*, page 14.

[466] ICA, *Submission to Review*, page 18.

[467] Ibid, page 42.

[468] R Tooth, *Submission to Review*, page 15.

[469] ICA, *Submission to Review*, page 18.

[470] Ibid.

[471] Law Society of NSW, *Submission to Review*, page 15.

[472] Law and Justice Review, *Hearing Transcript*, 26 May 2021, page 36 (Ms Donnelly).

price, seen through "more frequent price changes" and the reduced average premium base rate. It also points to SIRA's Greenslip Calculator as promoting greater competition and transparency.[473]

Dr Tooth believes that there is evidence that the Scheme is failing to achieve "most elements" of this objective, stating:[474]

- "*The level of competition in CTP (by any normal measure) is less than in (non-third party) motor vehicle insurance.*
- *Relative to comparable markets overseas, there has been negligible innovation. The most notable example is the lack of usage-based insurance.*
- *As noted above, there is substantial (and consistent) international evidence that rate regulation leads to higher overall costs and consequently higher premiums*."

Based on these observations, the submissions suggested changes to the Scheme to better secure the objective and promote competition on premium.

Suncorp recommends the simplification of the premium filing process, noting that the current process takes from 12 to 18 weeks to implement. It proposes to do this by:

> "*identifying steps in the process that can be removed or expedited where the proposed price change is within 4% of the current premium. This change will provide insurers with a mechanism to quickly implement a price change, allowing the benefits of increased price competition to reach more customers quickly*".[475]

However, it cautions against this process being automated.[476]

The ICA notes that, in the insurers' experience, the innovation clawback provisions in the TEPL involve "*an overly cumbersome administrative process to utilise which could be improved with simplification and streamlining*".[477]

Dr Tooth considers that it would be desirable that:[478]

- "*insurers can seamlessly bundle CTP and motor vehicle insurance into a single product*
- *insurers' incentives to prevent road crashes that cause death and injury align with that of society*
- *there are no barriers imposed by the scheme that prevent insurers from pricing for, and managing, risk (with minor qualification)*
- *regulatory barriers to entry and exit and [sic] minimised*."

To achieve these goals, he recommends the following changes to the Scheme:[479]

- "*removal of unnecessary licence conditions*

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[473] Suncorp, *Submission to Review*, page 10.

[474] R Tooth, *Submission to Review*, page 15.

[475] Suncorp, *Submission to Review*, page 11.

[476] Ibid.

[477] ICA, *Submission to Review*, page 19.

[478] R Tooth, *Submission to Review*, page 15.

[479] Ibid.

- *removal of rate regulations (including bonus/malus) and the risk equalisation mechanism*
- *removal of premium filing requirements*
- *removal of the profit normalisation measures*."

Innovation in the setting of premiums

The Australasian College of Road Safety advocates for a "*Safe Systems Approach*" to premiums, where novice drivers, who are considered higher risk, could better afford newer and safer cars through incentives from government.[480] The Motorcycle Council of New South Wales also advocates for this approach, and considers that the cost of injuries occasioned as the result of a road defect should be borne by the "*Road Authority who has an obligation to provide a safe road network. The cost shouldn't be borne by CTP policy holders.*"[481]

SIRA states that it has received innovation submissions under the TEPL Guidelines since the Scheme commenced but that it is unable to disclose specific details of individual submissions due to their commercial in confidence nature.[482] The Review is not aware whether any innovations submitted for approval of "innovation support" under the TEPL Guidelines relate to the setting of premiums.

In terms of innovations stakeholders believe would benefit the Scheme, Dr Tooth considers risk-based pricing, risk-based discounts and telematics-enabled usage-based insurance, enabled by the removal of rate-regulations, would be significant.[483]

The ICA considers the simplification and streamlining of the "cumbersome administrative process" involved with the innovation clawback mechanism in the TEPL would be beneficial.[484]

Suncorp is of the view that it is too soon to know whether innovations in premium setting would benefit the Scheme, and that the outcomes of the REM and TEPL innovations should be monitored before assessing other innovations.[485]

Point to point industry

In hearings before the Law and Justice Review, the NSW Taxi Council submitted that "*a true levelling of the playing field will only be achieved if all point to point service providers, including taxis, were grouped in class 1 for CTP*."[486] This proposal for change is not supported by SIRA, which considers it appropriate to keep ordinary passenger cars and taxis in separate classes for the purposes of premium calculation and to encourage safer driving.[487]

The NSW Taxi Council's written submission to the Law and Justice Review pointed out that taxi operators currently have to pay more for CTP insurance up-front than rideshare operators, and, unlike rideshare operators, do not have the ability to pass on the "pay as you go" distance-travelled part of the premium to

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[480] Australasian College of Road Safety, *Submission to Law and Justice Review*, page 13.

[481] Motorcycle Council of NSW, *Submission to Law and Justice Review*, page 5.

[482] SIRA, *Submission to Law and Justice Review*, page 18.

[483] R Tooth, *Submission to Review*, page 16.

[484] ICA, *Submission to Review*, page 19.

[485] Suncorp, *Submission to Review*, page 11.

[486] Law and Justice Review, *Hearing Transcript*, 25 May 2021, page 9 (Mr Rogers).

[487] SIRA, *Standing Committee on Law and Justice 2020 Review of the Compulsory Third Party Insurance Scheme: Pre-hearing questions for SIRA*, page 4.

customers.[488] Ultimately, the NSW Taxi Council advocates for change such that there be "*no commercial disparities between Taxis and Rideshare*".[489] The NSW Taxi Council is concerned that the current reform agenda for the point to point industry will not address commercial disparities for small business operators in the industry.[490]

The Review did not receive a submission from the NSW Taxi Council nor other participants in the point to point industry (apart from insurers).

Dr Tooth considers that it is better that the Scheme be neutral as to types of businesses and vehicle.[491]

Suncorp suggested that "*SIRA may wish to consider a tender option model for the Taxi Industry whereby all insurers can compete in a tender process to become the sole CTP insurance provider*."[492]

SIRA's role in ensuring the sustainability and affordability of the Scheme

The Review is not aware of any issues that have been raised with the legislative framework to give SIRA a role in the sustainability and affordability of the Scheme and fair market practices. It is clear that SIRA does have a significant role. The Review sought feedback as to whether there are any changes to the Scheme that should be considered in respect of SIRA's role as to these matters so as to better secure this policy objective. The ICA noted that SIRA has an important role, however given "*the stage of development of the Scheme with somewhat limited experience with SIRA's exercise of [some of its] powers*", it was not possible for the ICA to more definitively consider whether SIRA's role in relation to sustainability, affordability and fair market practices was adequate and appropriate.[493]

Other submissions were received that were directed toward SIRA having a greater role in the Scheme, for the benefit of claimants. A confidential submission to the Review recommended that SIRA should have the power to impose fines on insurers for poor claims management by insurers, as well as for "inappropriate and unprofessional behaviour". Repeated failures, according to this submission, should lead to insurers' licences to provide CTP insurance under the Scheme being revoked.

Insurers' staff

One of the recurring themes during the consultation meetings was a dissatisfaction with the way claims are handled within the claims departments of the CTP Insurers. The impact of claims staff, in particular, was a point of emphasis. Many stakeholders emphasised the importance of stability and continuity in a claimant's point of contact with the insurer. Consistency of messaging was another area that stakeholders agreed would assist claimants and the people around them. One stakeholder said that a good claims manager can make a great deal of difference to a person's claim and recovery, and that enhanced education for persons performing these roles would be beneficial.[494]

As we understood it, a number of participants in the consultation meetings and in submissions pointed out that insurers' staff have key performance indicators, and are subsequently paid bonuses, on the basis of the number of claims files they close. These participants were of the view that such practices incentivise poor behaviour. Dr Chesterfield-Evans considers that insurers "should be prohibited from providing incentives for

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[488] NSW Taxi Council, *Submission to Law and Justice Review*, page 11.

[489] Ibid, page 16.

[490] Law and Justice Review, *Hearing Transcript*, 25 May 2021, page 17 (Mr Rogers).

[491] R Tooth, *Submission to Review*, page 16.

[492] Suncorp, *Submission to Review*, page 11.

[493] ICA, *Submission to Review*, page 20.

[494] Medical and Allied Health, Consultation Meeting.

these clerks not to treat people."[495] Other stakeholders considered that the insurers' staff, while given good training, may have no background in personal injury or health. The process-driven nature of the Scheme, they assert, has led to some experienced claims officers leaving the CTP area.

Objective (f) – Deterring fraud

The Law and Justice Committee's *2018 Review of the Compulsory Third Party insurance scheme* included consideration as to whether the Scheme had reduced the opportunities for fraud and exaggeration. This had been one of the government's aims in introducing the 2017 reforms, reflected in Objective (f). The conclusion was:[496]

> "*At this early stage of 'a long tail' insurance scheme, particularly where common law damages cannot be pursued for 20 months, there is insufficient data available to examine whether there has been a reduction of claims fraud and exaggeration. SIRA noted, however, that no claims have been rejected or denied for fraud under the new scheme as at 31 August 2018. Further, there have been no claims where an insurer has alleged fraud on the part of the claimant or service provider.*"

There was agreement among the submissions to the Review that this objective remains valid.[497] Notwithstanding this, the ALA considers that the term fraud is used "too broadly and too loosely", particularly in relation to "claims harvesting".[498]

SIRA's 2019-20 Annual Report stated the following in relation to fraud in CTP Scheme (including both the current Scheme and the 1999 Scheme):[499]

> "*SIRA continues to work collaboratively with the NSW Police Force Financial Crimes Squad, other government departments, and peak investigative bodies to detect, deter and prosecute suspected unlawful activity involving the CTP scheme. As at 30 June 2020, 35 individuals had been charged by the NSW Police with a total of 209 fraud-related offences, and an estimated value of $16.6 million. The NSW Police have been heavily engaged in judicial processes over the 2019-20 financial year, with investigations continuing into plaintiff lawyers, medical practitioners, and intermediaries.*"

As at 31 August 2020, two additional individuals had been charged with eight additional offences.[500]

Among the submissions from stakeholders, there was a significant split as to whether the terms of the Scheme are appropriate for securing Objective (f). Suncorp is of the view that the terms are appropriate, and that the requirement to lodge a statutory benefits claim within 28 days of the accident and limitation on statutory benefits for minor injuries are appropriate. Suncorp considers that the Scheme "*provides sufficient controls, obligations and processes in place … to properly manage a claim and to prevent leakage from the claims process*."[501] The ALA considers that the Scheme has deterred fraud.[502] However, it and the Law

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[495] A Chesterfield-Evans, *Submission to Review*, page 9.

[496] Law and Justice Committee, *2018 Review of the Compulsory Third Party Insurance Scheme*, paragraph [2.34] (footnotes omitted).

[497] ALA, *Submission to Review*, page 13; *a confidential submission*; ICA, *Submission to Review*, page 21; Law Society of NSW, *Submission to Review*, page 16; Suncorp, *Submission to Review*, page 11.

[498] ALA, *Submission to Review*, page 13.

[499] SIRA, *2019-20 Annual Report*, page 38.

[500] SIRA, *Submission to Law and Justice Review*, page 19.

[501] Suncorp, *Submission to Review*, page 12.

[502] ALA, *Submission to Review*, page 13.

Society of NSW contend that the measures have "unduly eliminated compensable entitlements" and "over-delivered" on securing the objective.[503] The Law Society of NSW points, in particular, to the $75,000 cap on "contracting out" and the 20 month waiting period for damages claims as issues in this respect.[504]

In contrast, the ICA considers there is "more that can be done … to reduce the cost and behavioural impacts of fraud in the Scheme", contending that its experience suggests that fraud is present in the Scheme.[505] A stakeholder considers that the provisions of the Act are not clear on how penalties and remedies are to be implemented, "*particularly in circumstances where insurers are required to and have already commenced payment of statutory benefits on receipt of the claim and after receipt of evidence in relation to capacity for employment and pre-accident weekly earnings*."[506] This comment was reinforced during a consultation meeting with that stakeholder.

A stakeholder asserted that although claimants are required to provide evidence as to fitness for work, with insurers able to suspend weekly payments if they do not, the same power is not available in relation to evidence of pre accident employment or income. It considers that this "does not promote the deterrence of fraud." It notes that although there are provisions that allow for recovery of payments made on the basis of false or misleading information, "there can be considerable cost and practical difficulties in recovering these payments."[507] In addition, it points to a lack of clarity in the Act around the process for insurers to establish false and misleading conduct.[508] It considers that it is evident, from published decisions, that these penalties and remedies are not being utilised.[509]

Both the ALA and a confidential submission consider that there should be more transparent reporting about fraudulent claims, which for the ALA makes it difficult to make an assessment of the utility of the Act's provisions in this respect.[510] The ICA notes that insurers have "*amassed examples of behaviour that is contrary to the objectives of the legislation and consistent with fraud*",[511] and that insurers should have "*greater access to the services necessary to discharge its fraud related statutory obligations*".[512]

The ICA, in a consultation meeting, noted 4 specific areas of concern in relation to fraud under the Scheme, being (as we understood them):[513]

1. Emerging concerns with claim fraud, particular in relation to what was referred to as the "reverse onus of proof" where, for example, an insurer is put to proof as to fault in the situation of a single vehicle accident.

2. Problems with the insurers receiving underpayments on premiums and levies, often as a result of a person nominating the wrong vehicle class or garaging address when purchasing the insurance.

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[503] Ibid; Law Society of NSW, *Submission to Review*, page 16.

[504] Law Society of NSW, *Submission to Review*, page 16.

[505] ICA, *Submission to Review*, page 21.

[506] *A confidential submission*.

[507] Ibid.

[508] Ibid.

[509] Ibid.

[510] ALA, *Submission to Review*, page 14; *a confidential submission*.

[511] ICA, *Submission to Review*, page 21.

[512] Ibid.

[513] ICA, Consultation Meeting.

3. Problems with the process used to access tools, particularly legal advice, to fulfil insurers' statutory duties in relation to fraud.

4. Concerns about asymmetry in the drafting of the objectives and duties, meaning that while insurers are attempting to detect fraud, there has not been visible prosecution of fraud.

In response to a question about specific measures directed towards the deterrence of fraud in the Scheme, there was a common response that stakeholders did not have the appropriate data to respond.

SIRA considers that the "minor injury" framework "*has successfully reduced the ability for people to abuse the system*."[514] Suncorp's view is that it has limited the number of claimants lodging damages claims and settling the claim for a nominal sum.[515] The ICA considers that the minor injury framework,

> "*in concert with other design features, such as the removal of lump sum payments for treatment and care, appears to have reduced the incidence of one type of fraud, the low severity injury claims fraud that increased cost in the previous scheme*."[516]

A confidential submission, similarly, states that the minor injury framework has been successful in relation to claims for significant impairment stemming from "minor motor accidents and minor soft-tissue injuries only".[517] The Law Society of NSW considers that it has been "over-effective in reducing the available support for claimants with 'minor' injuries."[518]

The Law Society of NSW, the ICA, Suncorp and a confidential submission were of the view that it is difficult to assess the efficacy of the penalties for fraud in deterring fraud,[519] with the confidential submission stating "*There is presently no evidence that the fraud penalties provided for under the Act have been invoked or how such penalties would be invoked in practice*."[520]

In respect of SIRA's power to investigate claims, the Law Society of NSW further indicates that it is difficult to assess without comparative data.[521] A stakeholder pointed out that there is no clear process as to how fraud is to be investigated by SIRA,[522] and the ICA considers "*the existence of powers in the absence of their use (as we understand it) does little to deliver against Objective (f).*"[523] Suncorp is supportive of the powers and encourages SIRA "*to consider opportunities to increase the visibility of successful fraud prosecutions such that they act as a deterrent*."[524]

There are obligations on insurers to take steps to deter and prevent fraudulent claims across the life of a claim. The Law Society of NSW considers that comparative data is required to assess this measure's

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[514] SIRA, *Submission to Law and Justice Review*, page 18.

[515] Suncorp, *Submission to Review*, page 12.

[516] ICA, *Submission to Review*, page 21.

[517] *A confidential submission*.

[518] Law Society of NSW, *Submission to Review*, page 17.

[519] Ibid; ICA, *Submission to Review*, page 22; *a confidential submission*; Suncorp, *Submission to Review*, page 12.

[520] *A confidential submission*.

[521] Law Society of NSW, *Submission to Review*, page 17.

[522] *A confidential submission*.

[523] ICA, *Submission to Review*, page 22.

[524] Suncorp, *Submission to Review*, page 12.

efficacy.[525] A stakeholder considered that although the obligations are clear, there should be clearer mechanisms to enforce findings or assertions of fraud, and a dispute resolution process in place.[526] The ICA makes comment that:[527]

> "*Insurers are eager to discuss with SIRA options for incentivising innovation in the detection and prevention of fraud and to work together to relieve motorists of the unnecessary financial burden that fraud places on them*."

In terms of addressing issues for insurers, the ICA seeks "greater structural supports for Insurers",[528] while Suncorp does not believe prescriptive obligations for insurers is the best way to deter fraud.[529]

Finally, a confidential submission stated that the regulated cost structure as applied to insurers (as opposed to claimants) "*stymies the ability to engage legal representation to properly investigate and defend fraudulent claims*".[530]

SIRA's "CTP fraud" website states the following:[531]

> "*We have been working with insurers and other agencies to identify, manage and deter fraudulent claims by:*
>
> - *analysing data across the industry*
> - *reporting trends and suspicious issues to the CTP Green Slip insurers*
> - *encouraging insurers to adopt best practice fraud identification and prevention strategies*
> - *monitoring and collating the results of insurer initiatives*
> - *working with multiple agencies to facilitate the investigation of suspicious activities*
> - *exploring overseas experiences related to personal injury fraud*
> - *establishing a multi-agency taskforce and providing resources to investigate CTP fraud in NSW*
> - *setting up the CTP Insurance Fraud hotline with the Insurance Fraud Bureau of Australia so members of the public can report suspected fraud.*"

Regarding SIRA's function of detecting fraud, the Law and Justice Committee's *2018 Review of the Compulsory Third Party insurance scheme* noted SIRA's view that its data monitoring capabilities (involving detailed, close-to-real-time data received from insurers) had allowed it to investigate a medical provider for alleged potentially fraudulent behaviour.[532]

However, the NSW Taxi Council recently submitted to the Law and Justice Review that SIRA "*does not seem to have the appropriate level of data to identify* [accidents involving Rideshare Services] *due to the non-conforming nature of Rideshare Providers not taking out the correct policy and also not being identified as a Rideshare Provider when a claim is submitted.*"[533] The NSW Taxi Council recommends that it be made

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[525] Law Society of NSW, *Submission to Review*, page 17.

[526] *A confidential submission*.

[527] ICA, *Submission to Review*, page 22.

[528] Ibid.

[529] Suncorp, *Submission to Review*, page 13.

[530] *A confidential submission*.

[531] SIRA, *CTP fraud* <https://www.sira.nsw.gov.au/fraud-and-regulation/preventing-fraud/ctp-fraud>.

[532] Law and Justice Committee, *2018 Review of the Compulsory Third Party Insurance Scheme*, paragraph [2.162].

[533] NSW Taxi Council, *Submission to Law and Justice Review*, page 12.

"*mandatory for all Rideshare Providers to upload all vehicles within their fleets to the Point to Point Transport Commission Portal. Other agencies such as SIRA are to have access to the Portal for Compliance and Audit purposes.*"[534]

Penalties

In respect of the penalties for dishonesty, the NSW Taxi Council's submission to the Law and Justice Review recommended the introduction of "*tougher legislation around misreporting of CTP claims and tougher consequences for those who do not take out the correct policy or for any fraudulent activity*."[535]

Objective (g) – Claim and dispute resolution

Most submissions made on Objective (g) agreed that it remains valid.[536] However, the achievement of this objective was doubted by most submissions. The ALA and a confidential submission consider that the complexity of the Act in general, and the claims and dispute resolution provisions in particular, hinder the achievement of Objective (g).[537] The Law Society of NSW also considers that some of the Act's mechanisms "can delay the quick, cost effective and just resolution of disputes."[538] The ICA, however, considers that the terms of the Scheme are appropriate for securing the objective, but notes that the scheme is yet to mature. It considers that many of the dispute resolution mechanisms have not "been utilised in sufficient numbers to undertake a comprehensive analysis."[539]

In terms of ways the terms of the Scheme are not appropriate for securing the objective, the Law Society of NSW points to section 6.20 of the Act, which allows an insurer to determine a claim for a second time in relation to a claim for damages. This, in tandem with the 20 month waiting period in relation to lodging a claim for damages, according to the Law Society of NSW, "may lead to injured persons running out of time to commence proceedings within three years."[540]

The ALA points to the following difficulties in relation to the Scheme not achieving Objective (g):[541]

(a) "*The complexity of the Act, Regulations and Guidelines.*

(b) *The combative approach still adopted by CTP insurers in relation to claim management.*

(c) *Extensive delays in insurers providing internal review.*

(d) *The fact that legal representation leads to better results for claimants in terms of both success with disputes and the level of benefits/compensation recovered.*

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[534] Ibid, pages 4 and 12 (see Recommendation 4).

[535] Ibid, pages 4 and 13 (see Recommendation 5).

[536] ALA, *Submission to Review*, page 14; *a confidential submission*; ICA, *Submission to Review*, page 24; Law Society of NSW, *Submission to Review*, page 18; Suncorp, *Submission to Review*, page 13; IRO, *Submission to Review*, page 6. A confidential submission to the Review disagreed that Objective (g) remains valid.

[537] ALA, *Submission to Review*, page 14; *a confidential submission*.

[538] Law Society of NSW, *Submission to Review*, page 18.

[539] ICA, *Submission to Review*, page 24.

[540] Law Society of NSW, *Submission to Review*, page 18.

[541] ALA, *Submission to Review*, pages 14 - 15.

(e) *The chronic delays at DRS/the PIC. These delays extend far beyond those that have been caused by the pandemic*."

A stakeholder points to the "process driven" nature of the Scheme, which they consider prevents claims from being looked at holistically, and prevents achievement of a "quick" outcome. It also considers that "*the current timeframes associated with lodgement of an Application for Common Law Damages claim form and assessment of damages is counterintuitive to achieving a quick outcome and has created a backlog in the system and/or the lodgement of an Application for Common Law Damages claim form prematurely.*"[542]

Further, the Law Society of NSW observes that:

> "*it is our members' experience that irrespective of the severity of a claimant's injury, our members are rarely seeing concession of greater than 10% WPI since the Scheme began on 1 December 2017. It is common knowledge that there are very significant delays in determination by the PIC of both minor injury and treatment disputes currently averaging at about 8-9 months*."[543]

Various stakeholders made submissions on changes that could be made to the Scheme to improve the achievement of this objective. It is the IRO's preliminary view that "any reforms in this area should aim to reduce complexity and streamline dispute management."[544] In a consultation meeting with the IRO, the point was made that a number of disputes that end up in the PIC could have been resolved much earlier and more satisfactorily if they had been the subject of a complaint.[545]

LTCSA considers that clarification is required in relation to "*when claims may be made against the Nominal Defendant when motor vehicles involved in an accident are uninsured*", and considers that powers to access police information would be of assistance.[546]

The ALA's primary suggestions were:[547]

(a) "*Reduce the number of internal review requirements to those areas where internal review actually has some efficacy (primarily treatment disputes and wage disputes). Let disputes over minor injury, liability to pay statutory benefits post six months and the 10% WPI threshold proceed straight to medical or legal determination by the PIC.*

(b) *If there is going to be internal review, then only require one internal review per dispute category per claim.*

(c) *Provide some limitation upon an insurer's capacity to reverse its position with regards minor injury and reverse its position on an admission of liability for statutory benefits years after the accdent [sic]. At present, an insurer can put both the minor injury threshold and liability in dispute for a statutory claim at any point in the life of the claim, even if that is twelve months or twelve years after concessions are first made as to minor injury or liability for statutory benefits post six months.*

(d) *Where there is a NSW insurer handling a claim for the Nominal Defendant do not allow the interstate insurer to revisit minor injury in the damages claim.*"

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[542] *A confidential submission*.

[543] Law Society of NSW, *Submission to Review*, page 18.

[544] IRO, *Submission to Review*, page 6.

[545] IRO, Consultation Meeting.

[546] LTCSA, *Submission to Review*, pages 6 - 7.

[547] ALA, *Submission to Review*, pages 16 - 17.

The Law Society of NSW submitted that the 20 month waiting period should be removed or reduced to 12 months.[548] This view was shared by another stakeholder.[549]

The Law Society of NSW also considers that the current requirement for a claimant to submit two application forms (one for statutory benefits, one for common law damages) should become an amalgamated form. The "preferred process" would be that where the claimant makes one application, the insurer would review this claim at a specified time, and determine whether the claimant can claim common law damages. The process would include "*a mechanism whereby the insurer actually prompts the claimant to pursue common law damages and trigger this process*". In essence, if a claimant "*gets through the minor injury threshold and is not at fault, the insurer should then automatically be required to assess liability for common law damages, rather than waiting for a new claim form to be submitted*."[550]

The IRO recommends that Guideline 4.34 be "amended to specifically require insurers to provide information about the IRO to claimants".[551]

Stephen Young Lawyers considers that the IRO's function "does not deter the Insurer, and they will continue" to act the way that resulted in the IRO complaint.[552]

Groups and individuals associated with participation in the Scheme recommended that there be clearer information from SIRA in relation to the claims process, such as through a "Consumer Guide to CTP" or a booklet that outlines the claimant's rights, expectations from claims staff, and assistance, complaints and disputes processes. This, they assert, should be provided by SIRA and the CTP Insurers.[553]

The joint medico-legal process should be incentivised through amendments to the Guidelines, according to the Law Society of NSW.[554] Incentivising joint medico-legal assessments was a point of agreement among stakeholders, however there was no clear solution as to how this should be achieved.[555] One process that was suggested was that in the event of a disagreement among the parties as to who should complete the assessment, a PIC medical assessor would be nominated.[556] The ALA considers that although using a PIC medical assessor would be the solution, this is unlikely to work considering the pressure on the PIC already and a lack of doctors trusted by both insurers and claimant lawyers.[557]

A stakeholder considers that insurers should have greater powers to obtain information and evidence relevant to claims. It suggests this be done by modifying the claim form, to ensure claimants provide evidence that will assist in assessing liability and calculating PAWE.[558]

Suncorp considers it is:

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[548] Law Society of NSW, *Submission to Review*, page 19.

[549] *A confidential submission*.

[550] Law Society of NSW, *Submission to Review*, page 19.

[551] IRO, *Submission to Review*, page 7.

[552] Stephen Young Lawyers, *Submission to Review*, page 5.

[553] Road Trauma Support Group NSW, Consultation Meeting.

[554] Law Society of NSW, *Submission to Review*, page 19.

[555] ICA, Consultation Meeting.

[556] Law Society of NSW, Consultation Meeting.

[557] ALA, Consultation Meeting.

[558] *A confidential submission*.

"*important for the PIC to provide data on overturned assessment outcomes where new information has been provided and considered as part of the dispute. This important Scheme data can be used as a benchmark and opportunity for all insurers to continuously improve on performance and customer outcomes*."[559]

The Road Trauma and Support Group NSW recommends that the Review considers "*the merits of an independent body across all CTP insurers to manage all death claims to ensure greater consistency in management and administration of most serious claims*".[560] That body also considers that there should be a simplification of the processes and policies involves in making a claim, to "ensure that those that are entitled to bring a claim are not deterred by the process".[561]

Statutory benefits: resolution of claims

The Act requires relatively prompt submission of claims for statutory benefits. There are two key provisions underlying this requirement:

1. the loss of statutory benefits in respect of the period before claim submission, if submission occurs more than 28 days after the motor accident concerned; and
2. the time limit of 3 months for submission, subject to extension if the claimant provides a "full and satisfactory" explanation for the delay.

As to the first of these provisions, some stakeholders have expressed concern that this could operate inappropriately where the claimant is prevented through no fault of their own from making the claim within 28 days of the accident.[562] The Act provides no mechanism for relief for an injured person even in such circumstances. The Law Society of NSW considers that all time limits in the Act (and, the Review understands, the legislated consequences for lateness) should be reviewed, and the ALA considers that the Act is "*full of penalty provisions that impose harsh financial penalties … on claimants who fail to meet deadlines.*"[563] The ALA and the Law Society of NSW do not consider that this provision supports the achievement of Objective (g).

In comparison, the ICA and Suncorp consider that this requirement encourages early resolution of claims, however both these stakeholders also consider that applying this requirement "without exception"[564] "can disadvantage those who are unaware of the requirement".[565]

On the basis that there is no discretion for an insurer to backpay a claimant if they claim outside of the 28 day timeframe, Suncorp suggests that "*SIRA consider providing regulatory relief to insurers to approve discretionary backpay on a case by case basis. This would particularly benefit injured claimants whose physical or psychological injuries prevent them from submitting a claim within the stipulated timeframe*."[566] The IRO also considers that Objective (b) would be supported "*if amendments were made to provide*

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[559] Suncorp, *Submission to Review*, page 13.

[560] Road Trauma Support Group NSW, *Submission to Review*, page 3.

[561] Ibid.

[562] Law Society of NSW, *Submission to Law and Justice Review*, page 12; ALA, *Submission to Law and Justice Review*, page 15; ALA, *Submission to Review*, page 17; Law Society of NSW, *Submission to Review*, page 19.

[563] Law Society of NSW, *Submission to Law and Justice Review*, page 12; ALA, *Submission to Law and Justice Review*, page 15.

[564] ICA, *Submission to Review*, page 25.

[565] Suncorp, *Submission to Review*, page 13.

[566] Ibid.

insurers with a discretion to pay weekly benefits from the date of accident in cases where a claim was lodged outside of the 28-day time frame provided there is a full and satisfactory explanation."[567]

As to the second of the above provisions, the "full and satisfactory" test for an explanation by a claimant operates in several provisions of Part 6 of the Act in two distinct circumstances: non-compliance with a duty (i.e. an obligation on the claimant) or failure to meet a time limit relating to a claim. In both cases, there is a threshold objective requirement for an explanation to be considered "satisfactory". 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.

With respect to the "satisfactory" test that insurers apply, the ICA and Suncorp consider that insurers apply the test objectively, consistently with section 6.2(2).[568] In the Law Society of NSW's view, insurers "have been applying the test narrowly."[569]

The 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 ALA and the Law Society of NSW both consider that the test relating to non-compliance with a duty should be amended to align with the test required for a "satisfactory" explanation for delay.[570] The ICA and Suncorp do not consider that there is a need for amendment in this respect.[571]

In relation to insurers investigating claims in the course of seeking to resolve claims, there was a concern raised by the Road Trauma Support Group NSW that an insurer may go to great lengths to determine the facts, which the group is concerned may breach privacy laws and criminal investigation protocols. It recommends formulating appropriate guidelines for investigations, or establish an independent body for death claims in the Scheme.[572]

Damages: resolution of claims

The Law Society of NSW considers that the 20 month waiting period for damages claims where permanent impairment is not >10% is "*an unnecessary friction point in the scheme*" and is contrary to Objective (g), and that the prohibition on settling such a damages claim before 2 years have passed since the accident also adds unnecessary delay to resolution of claims.[573] Submissions made in respect of the 20 month waiting period for damages are outlined in relation to Objective (b) above.

Stephen Young Lawyers also expressed concern over an insurer's ability to change its minor injury determination from a non-minor injury, to minor injuries only, after an application for a damages claim has been lodged. It considers this is unfair for both claimants and their legal representatives.[574]

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[567] IRO, *Submission to Review*, page 5.

[568] ICA, *Submission to Review*, page 25; Suncorp, *Submission to Review*, page 14.

[569] Law Society of NSW, *Submission to Review*, page 19.

[570] ALA, *Submission to Review*, page 17; Law Society of NSW, *Submission to Review*, page 20.

[571] ICA, *Submission to Review*, page 25; Suncorp, *Submission to Review*, page 14.

[572] Road Trauma Support Group NSW, Consultation Meeting.

[573] Law Society of NSW, *Submission to Law and Justice Review*, page 7.

[574] Stephen Young Lawyers, *Submission to Review*, page 4.

Dispute resolution

Internal review

In 2020, insurers conducted 20 internal reviews per 100 claims on average.[575] Of the 1,737 determined internal reviews, 77% upheld the initial claim decision, 1% overturned the decision in favour of the insurer,[576] and 22% overturned the decision in favour of the claimant.[577] 81.9% of internal reviews were completed within the required timeframe.[578]

In the period 1 December 2017 to 31 December 2020, there were 17 independent determinations by SIRA's DRS, the predecessor to the PIC, per 100 claims.[579] In 41% of DRS determinations from 1 December 2017 to 31 December 2020, the insurer's decision was overturned.[580]

The ICA considers that these figures "*signify quality decision making on the part of insurers and certainty of fair and efficient outcomes for injured people where the insurer has erred in its decision-making*".[581] The ICA points out that the internal review process "*has enabled many disputes arising in the new scheme to be resolved without the need for escalation to SIRA's Dispute Resolution Service*" and "*can provide faster outcomes for injured people and reduce the cost and effort associated with referrals to DRS borne by injured people, insurers and the Scheme more broadly*."[582] The ICA considers that internal review provides a range of important benefits for claimants.[583] Suncorp considers that internal review supports Objective (g) as it can "drive continuous improvement and better decision making" and reduces the cost of disputes in the Scheme.[584]

In relation to minor injury, SIRA's Minor Injury Review found that internal review and DRS "*provide effective safeguards in ensuring that injuries are correctly determined as minor or non-minor*."[585]

The ALA questions the efficacy of internal review having regard to what it asserts is the low internal overturn rate compared with the relatively high DRS overturn rate, and the delay that the internal review process introduces before the claim comes before a "*neutral and objective decision maker*".[586] The ALA considers that some categories of dispute should be exempt from internal review,[587] and that a given claimant should

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

[576] 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.

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

[578] Ibid, page 9.

[579] Ibid, page 11.

[580] Ibid, page 11.

[581] ICA, *Submission to Law and Justice Review*, page 4.

[582] Ibid, page 3.

[583] Ibid; ICA, *Submission to Review*, page 26.

[584] Suncorp, *Submission to Review*, page 14.

[585] SIRA, *Minor Injury Review*, page 53.

[586] ALA, *Submission to Law and Justice Review*, page 33.

[587] Ibid, page 35; ALA, *Submission to Review*, page 17.

only be obliged to go through one internal review per category of dispute in the course of the claim.[588] It considers this can be achieved through regulation without needing to amend the Act.[589]

The Law Society of NSW considers that as "the internal review process often leads to delays", claimants should be given the option of proceeding directly to the PIC in relation to liability decision reviews, rather than first having to go through the internal review process.[590] In addition, it considers that claimant lawyers should be entitled to receive a fee for assisting in internal reviews even if the dispute does not escalate.[591] It considers that the internal review framework should be removed from the Scheme in its entirety.[592] In a consultation meeting, however, the Law Society of NSW considered that it should not be abandoned for all decisions, but certainly for minor injury disputes and probably WPI disputes.[593]

A stakeholder considers that medical disputes relating to WPI and medical treatment "should not be determined by non-medically qualified internal reviewers." It recommends that these disputes should proceed directly to the PIC for determination.[594]

Both the ICA and Suncorp support retaining internal review, however they both consider that there may be some categories of dispute (for example, those relating to WPI[595]) that may be better resolved by going straight to the PIC for determination.[596]

Other dispute resolution issues

The Law Society of NSW is concerned that claimants may suffer significant financial disadvantage if statutory benefits are cut off as a result of a decision by an insurer which is then submitted to the DRS (now, the PIC) and there is a delay in the determination of the dispute (particularly in light of the back-log of cases experienced by DRS during 2020).[597] It proposes a solution whereby the effect of an insurer's decision to stop or reduce statutory benefits would be stayed pending resolution of the dispute.[598] The ALA agrees, suggesting that "*where insurers make belated reversals of decisions such as invoking the minor injury threshold or challenging a liability to pay statutory benefits years after an initial favourable decision to the claimant, then the claimant should continue to receive benefits until the dispute is resolved*."[599]

Stephen Young Lawyers also considers that delays in resolving claims in the internal review and PIC processes, especially the way that affects a claimant's ongoing treatment, is "*not in line with the purpose of the Act*."[600]

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[588] Ibid, page 36.

[589] ALA, *Submission to Review*, page 17.

[590] Law Society of NSW, *Submission to Review*, page 20.

[591] Ibid.

[592] Ibid, page 21.

[593] Law Society of NSW, Consultation Meeting.

[594] *A confidential submission*.

[595] Suncorp, *Submission to Review*, page 15.

[596] ICA, *Submission to Review*, page 26; Suncorp, *Submission to Review*, page 15.

[597] Law Society of NSW, *Submission to Law and Justice Review*, page 8.

[598] Ibid.

[599] ALA, *Submission to Review*, page 18.

[600] Stephen Young Lawyers, *Submission to Review*, page 3.

However, the ICA and Suncorp do not agree that this should occur.[601] The ICA considers that such a change would undermine Objective (g), and "would provide an incentive for disputation regardless of merit."[602] Suncorp considers that as an insurer may be unable to recover the benefits paid if the eventual decision was in the insurer's favour, there would be a flow-on impact on Scheme costs and premium affordability.[603]

The Law Society of NSW also considers that a medical assessor's decision on the degree of impairment of an injured person's earning capacity (classified as a medical assessment matter) should not be binding on merit reviewers, the PIC or courts in relation to damages claims. This is because – as recognised in clause 8(3) of Schedule 1 to the Act – assessment of an injured person's fitness for work may depend on a range of factors in addition to a medical assessment of impairment.[604]

There was agreement among the relevant submissions that 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. The submissions considered that it would be beneficial to set out the relevant terms in Subdivision 3.[605]

The NSW Bar Association submits that insurers "*should be obliged to act as model litigants given the guaranteed profit which they are permitted to make through the compulsory levy of CTP premiums*".[606] In addition, the NSW Bar Association considers that the use by insurers of police opinion in liability disputes (i.e. disputes as to fault) should be reviewed, as police opinion can be used to persuade claimants that they were at fault even if there is a basis to question the validity of the opinion.[607]

Authorised Health Practitioners and medico-legal examinations

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.[608] The ALA considers that a regime for joint medico-legal examinations should be introduced to the Scheme.[609] It also considers that the system should be discarded, as the "*AHP regime has not seen any demonstrable improvement in the quality of medico-legal report writing within the Scheme*."[610] The Law Society of NSW considers that the AHP system "does not have a practical impact in relation to the quick, just and cost-effective resolution of a claim", and is particularly troublesome in specialty areas of medicine where complex opinions are required.[611]

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[601] ICA, *Submission to Review*, page 27; Suncorp, *Submission to Review*, page 15.

[602] ICA, *Submission to Review*, page 27.

[603] Suncorp, *Submission to Review*, page 15.

[604] Law Society of NSW, *Submission to Law and Justice Review*, pages 10, 11.

[605] ALA, *Submission to Review*, page 19; ICA, *Submission to Review*, page 27; Law Society of NSW, *Submission to Review*, page 21.

[606] NSW Bar Association, *Submission to Law and Justice Review*, page 18.

[607] Ibid, pages 17 - 18.

[608] ICA, *Submission to Law and Justice Review*, page 6; Law Society of NSW, *Submission to Law and Justice Review*, page 11; ALA, *Submission to Law and Justice Review*, pages 26 - 29.

[609] ALA, *Submission to Law and Justice Review*, page 25; ALA, *Submission to Review*, page 19.

[610] ALA, *Submission to Review*, page 19.

[611] Law Society of NSW, *Submission to Review*, page 22.

A stakeholder also considers that the AHP framework should be abandoned as it adds unnecessary administrative burden to the Scheme.[612] It also suggested a number of changes to the system in the alternative.[613] That stakeholder's confidential submission stated that "*the current system ought to revert to the previous system whereby parties were able to qualify a medico-legal report from any suitably qualified health practitioner, subject to the obligations to offer a joint medico-legal assessment. This enabled a wide selection of experts across urban and regional locations*."[614]

The Law Society of NSW considers that rather than requiring medical specialists to "opt in" to the report writing system that SIRA should retain "the power to discipline outliers in a procedurally fair way".[615]

There is a problem recognised by medical professionals involved in the Scheme in relation to medico-legal assessments, being the difficulties in having both parties agree to the same assessor where there is a perception that practitioners have either an insurer or claimant bent. Otherwise, there was an observation that files given to assessors have either an insurer or claimant-focused set of questions and requests.[616]

The ICA, in its submission to the AHP Framework Review and in consultation meetings with the Review, recommend that the AHP framework be discontinued and alternative approaches be explored.[617]

Legal representation, and legal and other costs

An Evaluation Report of the Legal Advisory Service published in May 2019 found that the service, which provides access to legal advice relating to statutory benefits claims for select matters, is meritorious, but that its effectiveness could be improved by better promoting the service, educating stakeholders and improving operational processes to proactively identify claimants who could benefit from the service.[618]

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.[619]

In terms of the restrictions on paid legal advice in connection with claims disputes, the ALA considers that the "data clearly identifies that there are unjust outcomes that flow from lack of legal representation."[620]

Stephen Young Lawyers considers that as there are some disputes that fall outside the merit review, medical assessment and miscellaneous claims assessment matters that legal practitioners cannot claim costs for, claimants are not able to be assisted in such disputes. It also considers that a set fee should be provided, rather than a maximum regulated fee, and that costs should not be capped at 60 monetary units per claim. It

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[612] *A confidential submission*.

[613] Ibid.

[614] Ibid.

[615] Law Society of NSW, *Submission to Review*, page 22.

[616] Medical and Allied Health, Consultation Meeting.

[617] ICA, *Submission to SIRA's Post Implementation Review of the Authorised Health Practitioner (AHP) Framework*.

[618] SIRA, *Independent Review of the Operation of SIRA's Legal Advisory Service Pilot*, pages 46 - 49.

[619] SIRA, *Submission to Law and Justice Review*, page 28.

[620] ALA, *Submission to Review*, page 19.

supports imposing penalties on insurers that deny claims for legal fees incurred. It also considers that the PIC should be given more guidance about exceptional costs.[621]

The Law Society of NSW highlights the issue that no legal fees are available for internal reviews. It considers that, if properly resourced, claimant lawyers could assist claims to be resolved earlier in the process. It considers that:[622]

> "*If claimant solicitors were to have access to ILARS funding in the motor accident Scheme, this would incentivise early and thorough investigation of claims with relevant documents being submitted to the insurer at the internal review stage. The certainty that costs for all services can be recovered facilitates earlier provision of advice to claimants on their prospects of success. Unmeritorious referrals to the PIC will be less likely to occur and PIC assessors will have greater capacity to assess other claims and provide a faster turnaround time for meritorious claims*."

A stakeholder considers that there is an "ethical bind" in the situation where insurers' legal representatives are unable to claim exceptional costs, and recommend that the regulations be amended to allow those costs to be claimed.[623]

The IRO considers that there is "*a substantial evidence base that indicates the current restricted access to paid legal advice do not help secure, and in all likelihood hinders the objectives of the Act*", and on that basis notes that the "*2022 review of the CTP scheme will provide a full opportunity to determine whether ILARS should be extended to CTP claimants*."[624] There was an acceptance in a consultation meeting, as we understood it, that this could occur sooner.[625]

A confidential submission considers that, on a more general level, the goal of avoiding legal support by limiting paid legal advice has not been achieved and should not in any event be a goal of the Scheme.

CTP Assist

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.[626]

In response to a question on this, the Law Society of NSW suggests that CTP assist could include carers in telephone calls that provide advice to injured persons.[627] The ICA and Suncorp consider that this is a matter for SIRA, but expressed their support for the role of carers.[628]

The ALA is of the view that there "*are far bigger and better questions to be asked about the role of CTP Assist and in particular, whether it provides legal advice and whether it provides accurate and*

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[621] Stephen Young Lawyers, *Submission to Review*, pages 1 - 2.

[622] Law Society of NSW, *Submission to Review*, page 22.

[623] A confidential stakeholder, Consultation Meeting.

[624] IRO, *Submission to Review*, page 8.

[625] IRO, Consultation Meeting.

[626] Carers NSW, *Submission to Law and Justice Review*, page 2.

[627] Law Society of NSW, *Submission to Review*, page 23.

[628] ICA, *Submission to Review*, page 28; Suncorp, *Submission to Review*, page 15.

comprehensive legal advice."[629] Members of the Law Society of NSW, in a consultation meeting, reflected that CTP Assist's ambit is general in nature and is not targeted at an individual's circumstances.[630]

A confidential submission received by the Review also advocated for the improvement of CTP Assist, finding the lack of personalised advice leads to "disingenuous" practices. An additional confidential submission considered that after being seriously injured, a cursory call from CTP Assist in the first few days post-injury was not adequate.

Objective (h) – Collection and use of data

Objective (h) is "*to ensure the collection and use of data to facilitate the effective management of the compulsory third-party insurance scheme*". The framework in place to achieve this objective gives SIRA very broad powers to collect and use information.

In its own recent observations concerning Objective (h), SIRA points to:[631]

- its CTP open data portal, designed to make it easy for consumers to compare data and insurers' performance. SIRA considers that this assists customers and injured persons and helps to hold insurers accountable to their obligations; and
- its partnership with Transport for NSW's Centre for Road Safety and its investment in data sharing, linkage and exchange between NSW Health and Ambulance, the NSW Police Force, Transport for NSW and icare Lifetime Care. SIRA considers that this enables SIRA to "*provide a more integrated approach to care, and a seamless experience for injured people*".

It is apparent from the materials before the Review that SIRA, in carrying out its functions under the Act, is aware of the need to supervise the collection and recording of relevant information by insurers and has regulatory powers to do so. For example, in its Minor Injury Review, in relation to return-to-work outcomes SIRA committed to "*use its regulatory powers to hold insurers accountable for improving their data collection processes*"[632] and "*apply its regulatory powers to monitor and guide insurers on documentation and communication processes.*"[633] In relation to assertions by insurers that it can be difficult to obtain information to make minor injury determinations, SIRA stated that it would "*work with insurers and other key stakeholders to determine how the information gathering process can be improved.*"[634]

The ALA, the ICA, Suncorp and the Law Society of NSW all consider that Objective (h) remains valid.[635]

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[629] ALA, *Submission to Review*, page 19.

[630] Law Society of NSW, Consultation Meeting

[631] SIRA, *Submission to Law and Justice Review*, pages 21 - 22.

[632] SIRA, *Minor Injury Review*, page 29.

[633] Ibid, page 50.

[634] Ibid, page 49.

[635] ALA, *Submission to Review*, page 21; ICA, *Submission to Review*, page 30; Suncorp, *Submission to Review*, page 16; Law Society of NSW, *Submission to Review*, page 23.

Some stakeholders have concerns that particular information should be available to SIRA,[636] or that SIRA should make certain data publicly available that it currently does not.[637]

The Law Society of NSW "would welcome greater transparency from SIRA in this area".[638]

While Suncorp considers that the terms of the Scheme "are broad and appear to be appropriate",[639] the ICA considers that as SIRA is able to require insurers to provide additional information "with limited notice", the Scheme would benefit by amending the Guidelines to "promote certainty in what must be provided to SIRA". The cost of meeting data requirements, the ICA contends, comes at a cost to the Scheme,[640] and can "*require insurers to allocate front line staff away from claims management functions that assist claimants and their recovery*."[641]

Suncorp points to ongoing changes to the Universal Claims Database (**UCD**) manual as evidence that SIRA is "*undertaking its role to ensure the collection and use of data is being used to facilitate the effective management of the CTP Scheme*".[642] The data collected by SIRA, according to the ICA, "has significantly increased".[643] However, the ALA considers that the publication of this data "has not been aggressive enough or effective enough".[644]

The ALA would see SIRA publish data on rates of withdrawal and concession of matters at the PIC, as well as data on settlement amounts proposed by insurers as against the eventual settlement amount as approved by the PIC where the claimant was unrepresented.[645]

LTCSA considers that the UCD could be used for early identification of claims "*where emerging experience may be inconsistent with optimal outcomes prior to the claim being transferred to the LTCSA*."[646]

In terms of changes to the Scheme to better achieve Objective (h), the ICA considers that there:[647]

> "*must be a clear and transparent framework through which a thorough cost benefit analysis is undertaken before additional data collection requirements are imposed. In line with objective (d) this process will also help ensure the regulator is able to efficiently collect the data they need to manage the scheme while minimising the impact on Scheme costs.*"

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[636] For example, the NSW Taxi Council considers that it should be mandatory "*for all Rideshare Providers to upload all vehicles within their fleets to the Point to Point Transport Commission Portal*" and for SIRA to have access to the information on the Portal (NSW Taxi Council, *Submission to Law and Justice Review*, pages 4, 12 (see Recommendation 4).

[637] For example, the NSW Bar Association considers that SIRA should make publicly available a range of data relating to the operation of the Scheme that it has not been able to obtain (NSW Bar Association, *Submission to Law and Justice Review*, page 10).

[638] Law Society of NSW, *Submission to Review*, page 24.

[639] Suncorp, *Submission to Review*, page 16.

[640] ICA, *Submission to Review*, page 30.

[641] Ibid, page 31.

[642] Suncorp, *Submission to Review*, page 16.

[643] ICA, *Submission to Review*, page 30.

[644] ALA, *Submission to Review*, page 21.

[645] ALA, Consultation Meeting.

[646] LTCSA, *Submission to Review*, page 3.

[647] ICA, *Submission to Review*, page 31.

Suncorp agrees there is a need for consultation and analysis prior to SIRA requiring additional data from insurers.[648] In a similar vein, the ICA suggests "*the publication of data be clear and concise. We consider the Act should identify high level categories of data for collection with more detail set out in a subordinate instrument such as the Regulation or Guidelines to provide more certainty and rigor in the process*."[649]

In terms of specific changes, Suncorp recommends the following changes to the UCD Manual:[650]

- that SIRA "*conduct proper consideration as to whether any of the data request is justified including its costs benefits*";
- that SIRA consider any appropriate improvements to assist insurers in regard to the UCD database's ability to immediately "refresh and review validations", and to minimise insurers' follow up administrative tasks; and
- "*that SIRA be provided with greater regulatory and enforcement powers in order to compel service providers (in the P2P industry) to provide information that is reasonably required to determine premiums*".

The ALA recommends that data pertaining to the following two areas should be published by SIRA:[651]

- Return to work data after the 26 week mark for those with minor injuries.
- Insurer success in "*procuring joint medico-legal examinations and the relative performance of insurers in that regard*".

The Law Society of NSW also considers that further data relating to "what happens to those with 'minor' injuries who exit the Scheme after 26 weeks" is required. It states that:[652]

> "*the SIRA Minor Injury Report published in February 2020 says that 70% of labourers have returned to work after 26 weeks. The Law Society queries what has happened to the 30% of labourers suffering from a minor injury who have not returned to work after 26 weeks. There is simply no analysis of what has happened to these workers. In our view, this data is necessary to properly evaluate the success of this aspect of the Scheme*."

[648] Suncorp, *Submission to Review*, page 16.

[649] ICA, *Submission to Review*, page 31.

[650] Suncorp, *Submission to Review*, page 17.

[651] ALA, *Submission to Review*, page 21.

[652] Law Society of NSW, *Submission to Review*, page 24 (citations omitted).

SIRA's regulation of the Lifetime Care and Support Authority

SIRA requested that the Review consider its "limited" ability to regulate the LTCSA "*in the exercise of its functions as the relevant insurer for the payment of statutory benefits for treatment and care*".[653] As it stands, SIRA is able to escalate concerns about LTCSA to the Minister but is unable to regulate it in the same way as it does the CTP insurers in the Scheme.

The Review invited LTCSA to make a submission on this matter. LTCSA stated that it did "not accept that the current level of regulatory oversight for SIRA is inadequate or inappropriate", and that there was, in its view, no need to modify the scope of SIRA's regulation.[654] The basis for this view was expressed through 5 matters:[655]

(a) that LTCSA is already subject to regulation, and that SIRA's proposal did not identify material benefits to justify the cost of increased regulation, particularly for a scheme that is yet to properly commence;

(b) that the role of LTCSA is "fundamentally different" to the 6 CTP Insurers in the scheme, as LTCSA is concerned only with providing treatment and care to injured persons from 5 years after the motor accident, and has no profit imperative;

(c) that SIRA already has some regulatory oversight of LTCSA, and LTCSA is "*also answerable to entities such as the Disability Ombudsman and the Disability and Ageing Commissioner*";

(d) that in relation to recommendations made in the statutory review of the *State Insurance and Care Governance Act* undertaken by Justice McDougall, it "*is not possible to transpose a solution for the one scheme onto the other, where those schemes are fundamentally different in purpose and operation*"; and

(e) that there will be opportunity to further review the relationship between LTCSA and SIRA when the scheme fully commences.

[653] SIRA, Letter to Clayton Utz and Deloitte dated 9 June 2021.

[654] LTCSA, *Supplementary Submission to Review*, page 1.

[655] Ibid, pages 2 - 4.

Minor injury

The framework in the Act for "minor injuries" is, apart from any other objective, required to help secure Objective (d) and also intended to help to secure Objective (f). However, the limitation on benefits for persons with only "minor injuries" has the potential to hinder the achievement of Objective (a) if the limitation itself is too severe or if "minor injuries" are not defined appropriately. The minor injury definition and application attracted the most attention in the submissions to the Review.

Limitations on statutory benefits for treatment and care

For persons with only "minor injuries", statutory benefits for treatment and care are limited to 6 months. However, under section 3.28(3) of the Act, together with clause 5.16 of the Guidelines, statutory benefits for certain categories of treatment and care past that time period may be available in defined circumstances. This exception to the 26-week limit may mitigate the potential hindrance of Objective (a). Further, the time limit is, at least to some extent, said to be justified on the basis that leaving the compensation system encourages earlier recovery and return to work and other activities.[656]

In its Minor Injury Review, SIRA noted that, for persons with "minor injuries" only, 42% of claims had a duration of 0-3 months, and 75% of injured persons' treatment and care were finalised within 6 months. 98% of "minor injury" claims had ended by week 52.[657] It follows that 25% of claimants continued to receive benefits after 26 weeks, under what SIRA describes as the "*safety net*" benefits available after that time in defined circumstances.[658] The ICA has described this as "*discretionary treatment*".[659] SIRA concluded that persons with only "minor injuries" who need further treatment at week 26 are supported.[660]

However, it was not clear how many claimants who sought treatment after 26 weeks were declined by the relevant insurer, whether by reason of assessment against the qualifying criteria in clause 5.16 of the Guidelines or on the exercise of a discretion by the insurer.

As to the possibility of extending the 26-week period for "minor injury" generally, SIRA expressed the concern that extending the period of benefits for "minor injuries" past 26 weeks is more likely to be detrimental to recovery than supportive of injured persons, and that the existing provisions are adequate to support injured persons beyond 26 weeks if required.[661]

Practitioners in the Scheme expressed the view, as we understand it, that delays in approving treatment and care means that the 26 week period passes quickly, which can compromise the continuity and efficacy of treatment. In addition, some observed that approvals for aids or equipment to assist treatment can be an extensive process that may hinder recovery.[662]

At the other end of the timeframe, LTCSA considers that the Act should be amended "*so that the ability to continue payment of benefits in respect of minor injuries ceases within 5 years of the motor vehicle accident*."[663]

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[656] SIRA, *Minor Injury Review*, pages 9, 26.

[657] Ibid, page 20.

[658] Ibid, page 22.

[659] Law and Justice Review, *Hearing Transcript*, 25 May 2021, page 27 (Ms Isley).

[660] Ibid, page 26.

[661] SIRA, *Standing Committee on Law and Justice 2020 Review of the Compulsory Third Party Insurance Scheme: Pre-hearing questions for SIRA*, pages 6, 7.

[662] Medical and Allied Health, Consultation Meeting.

[663] LTCSA, *Submission to Review*, page 5.

Definition of "minor injury"

SIRA's Minor Injury Review concluded that "*the minor injury definition and provisions have been successful in achieving the Act's objectives of encouraging early and appropriate treatment and care to enable people to achieve recovery and maximise their return to work or other activities.*"[664]

Important to this conclusion was the proposition that the "*minor injury definition has been generally successful in identifying those injuries where quick recovery is expected but there are some focus areas that require further monitoring by SIRA*."[665] Specifically:[666]

> "*The minor injury definition is designed to cover injuries from which a person is typically expected to recover within a short period of time. Scheme data supports that the definition mostly covers appropriate injury types. Almost all injury types that were covered by the definition showed a consistent pattern of recovery within 26 weeks.*
>
> *Only two types of injuries did not conform to the general trend, these are injuries coded as 'Spine Other' and `Psych'. Specifically, 59% of minor injury claims that contained a 'Spine Other' type injury were active beyond 26 weeks (185 claims of the NAF minor injury claims analysed). The average duration for these claims was 40 weeks. Scheme data also showed that 60% of psychological minor injury claims were active beyond the 26-week threshold.*"

According to SIRA, the prevalence of "Spine Other" injuries classified by insurers as "minor injuries" but requiring treatment and care beyond 26 weeks to improve recovery may be the result of incorrect classification by insurers,[667] and does not require amendment of the "minor injury" definition.

In relation to "Psych" injuries classified as "minor injuries", SIRA found that, in practice, psychological and psychiatric injuries are taking longer to be diagnosed than other injuries due to the "complex nature and usual progression" of such injuries.[668]

For classification as a "minor injury", a psychological or psychiatric injury must be either:

- a psychological or psychiatric injury that is not a recognised psychiatric illness; or[669]
- an acute stress disorder or adjustment disorder (as defined in the DSM-5).[670]

According to SIRA, these criteria were "*established to distinguish between injuries that will recover well with treatment within a short period of time and injuries that are more serious. Common minor psychological or psychiatric injuries include sub-syndromal symptoms of; stress, anxiety, fear, depressed mood, anger or guilt*."[671]

SIRA emphasises the importance of early intervention for psychological and psychiatric injuries and says that: "*Even if a psychological injury cannot be diagnosed, it is important injured persons who display symptoms are referred to a specialist where appropriate. This can prevent symptoms developing into a*

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[664] SIRA, *Minor Injury Review*, page 55.

[665] Ibid, page 30.

[666] Ibid.

[667] Ibid, section 4.4.

[668] Ibid, page 38.

[669] Section 1.6(3) of the Act.

[670] Regulations 4(2), 4(3) of the Regulations.

[671] SIRA, *Minor Injury Review*, page 38.

psychological injury at a later stage."[672] Further, SIRA has found that although psychiatric and psychological injuries can be diagnosed relatively soon after a traumatic event, this is generally not occurring in "minor injury" claims.[673]

Although only half of psychiatric and psychological injuries are being diagnosed by 3 months post-accident, insurers are required to notify claimants within 3 months of lodgement of the claim whether they consider the person's injuries to be "minor injuries" only.[674] SIRA considers that this situation can be improved by insurers screening for "minor injury" claims and facilitating appropriate referrals for early psychological assessment.[675] SIRA also considers that psychiatric and psychological injuries can and should be treated earlier than is currently occurring in the Scheme.[676]

The practical difficulty of early diagnosis of psychiatric or psychological injury appears to be reflected in the dispute data: 45% of "minor injury" disputes finalised by DRS between 1 December 2017 and 30 June 2019 related to psychiatric or psychological injuries resulted in overturning the insurer's decision, and 50% of the overturned decisions involved new evidence.

A medical practitioner was of the view, as we understand it, that psychiatric and psychological conditions could be diagnosed with a reasonable confidence by 13 weeks, however that might need to be reviewed at a certain time. However, there was also an identified problem with practitioners not making early referrals to a psychiatric assessment, in tandem with a view that early intervention is likely to reduce the cost burden on the scheme and return claimants to work sooner.[677]

Finally, SIRA has received feedback that the term "minor injury" is itself unsatisfactory.[678] This is because it is easily confused with a medical assessment of the extent or impact of a person's injuries and carries a negative connotation for people whose injuries are not "minor" in that sense or having regard to the ordinary meaning of that word. The term "minor injury" as used in the Scheme is a technical legal term for certain types of injury from which recovery is expected (or which are expected to stop improving with treatment) within 6 months of the accident. SIRA concluded in its Minor Injury Review that it had not received satisfactory suggestions for alternative terminology.[679]

The ICA submits, to the Review, that the use of the term "minor injury" can cause distress for some people, and would support using a different terminology, such as "short-term benefits claim", or introducing "Category A/Category B" descriptors.[680] Suncorp supports this on the basis that injured people feel that the term "minor" "trivialises their injury and its impact on their life", and welcomes engagement with SIRA on an alternative.[681]

The use of the term "minor injury" was a feature of a confidential submission, who stated that:

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[672] Ibid, page 39.

[673] Ibid.

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

[675] SIRA, *Minor Injury Review*, page 40.

[676] Ibid, page 41.

[677] Medical and Allied Health, Consultation Meeting.

[678] SIRA, *Minor Injury Review*, page 31.

[679] Ibid, page 32.

[680] ICA, *Submission to Review*, page 5.

[681] Suncorp, *Submission to Review*, page 5.

> *"To label a person's injury objectively is incredibly insulting and hurtful as it removes any acknowledgment of the severity of the clinical assessment and undermines the significance of the injury to the injured persons themselves … Calling our hurt and injury 'minor' is not fair.*"

Similarly, the IRO submitted that "*While a change of the term "minor injury" would not have changed the decision made by the insurer, it may have reduced the distress the injured person felt as a result of their injuries being deemed 'minor'*".[682] However, the IRO does not support the use of the term "*short term benefits injury … as it does not reflect accurately the range of statutory benefits available to the claimant*."[683] Other suggestions such as "self-limiting injury" and "short term recovery injury" were posited in consultation meetings.[684]

On the other hand, the ALA and the Law Society of NSW, while acknowledging the issues associated with the terminology, consider that the term "minor injury" has become familiar to stakeholders and make the point that changing the term may lead to greater confusion and adverse consequences.[685]

Comments were made in the consultation meetings that training for claims staff could be beneficial in "de-catastrophising" the minor injury term. It was observed that an acknowledgment that an injury is not minor to the claimant, but minor in relative terms, could go some way in ameliorating the insult and hurt experienced by some claimants.[686]

The legal effect of classification of an injury as a "minor injury" is that statutory benefits are available for a shorter period than otherwise, and damages claims are not allowed. The Discussion Paper asked a question regarding the alignment of the definition of "minor injury" with the kinds of injuries that would be expected to resolve within the period that statutory benefits are available.

The ICA considers that the "minor injury" definition and process has so far been generally working well, leading to both early treatment and early resolution of such claims.[687] Suncorp also considers the "minor injury" definition is aligned with appropriate injuries.[688] However, the ICA and Suncorp also acknowledge that applying the "minor injury" definition to claims involving psychological injuries, quoting the ICA, "*has occasionally presented challenges within the Scheme. This is primarily due to the greater complexity and difficulty diagnosing these injuries, and the requirement that insurers make decisions on these injuries within 3 months.*"[689]

The Law Society of NSW does not agree that the "minor injury" definition works well. It summarises its position as follows:[690]

> "*In the three years since the minor injury definition's introduction, anecdotal evidence available to the Law Society, including from our members, doctors and claimants, suggests the minor injury definition has resulted in a significantly harsher treatment of claimants than under the previous scheme. We are seriously concerned that this definition is operating to deprive many genuinely*

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[682] IRO, *Submission to Review*, page 3.

[683] Ibid, page 4.

[684] Medical and Allied Health, Consultation Meeting.

[685] ALA, *Submission to Review*, page 4; Law Society of NSW, *Submission to Review*, page 5.

[686] Medical and Allied Health, Consultation Meeting.

[687] ICA, *Submission to Law and Justice Review*, page 6.

[688] Suncorp, *Submission to Review*, page 5.

[689] ICA, *Submission to Law and Justice Review*, page 6; ICA, *Submission to Review*, page 6; Suncorp, *Submission to Review*, page 6.

[690] Law Society of NSW, *Submission to Law and Justice Review*, page 3.

injured people of appropriate benefits and compensation, despite the legitimacy and accepted reality of their injuries."

In its submission to the Review, the Law Society of NSW further articulated:[691]

> "*Given the above, it is clear that 26 weeks of statutory benefits can be inadequate for people who have sustained 'minor injuries' within the context of the Scheme. Greater consideration needs to be given to the individual real-life circumstances of the claimant to allow an extended period of recovery, to ensure that unfair and unjust outcomes are not commonplace.*
>
> *We reiterate the position we put forward in 2016 and 2019 directly to SIRA, that instead of the current 'minor injury' definition, a 'narrative test' should be developed, which includes objective evidence of physical and/or psychological injury, but that does not rely solely on a number (for example, a WPI percentage). Instead, such a test should also consider the consequences of the injury on a person …*"

The proposal of a narrative test was not supported by the Insurance Council of Australia in a consultation meeting.

The particular issues that the Law Society of NSW pointed out in its written submission to the Law and Justice Review may be summarised as follows:[692]

- The definition focuses on "*objectively proven pathology*" and not on the real-life impact of the injury on the injured person. This is said to lead to "*arbitrary, counterintuitive and unfair outcomes*", particularly where a person with only "minor injuries" has persistent symptoms and reduced work capacity for a period extending beyond 6 months, but has no entitlement to statutory benefits after 6 months and no recourse to damages.

- The provisions in Part 5 of the Guidelines relating to assessment of spinal injuries against the "minor injury" definition require amendment to avoid inappropriately capturing persons with significant ongoing pain and reduced work capacity. It is said that there should be a WPI limit incorporated into the definition of "minor injury".

- Psychological injuries are rarely evident immediately after an accident and delayed onset is usual. 3 months or even 6 months is not a sufficient time period within which to require assessment of psychological injuries against the "minor injury" definition. Further, the inclusion via the Regulations of "adjustment disorder" in the definition of "minor injuries" is not sufficiently nuanced because adjustment disorder may be either acute (which by definition is resolved within 6 months) or chronic. This point is also made by the ALA.[693]

The NSW Bar Association also holds the view that the "minor injury" definition is "*not fair, and it is not easy to apply*". Its submission to the Law and Justice Review supported including a 5% WPI limit in the "minor injury" definition.[694] The ALA considers that a 10% WPI limit should apply.[695] A confidential submission also considers there are difficulties with the requirements of the "minor injury" definition.[696]

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[691] Law Society of NSW, *Submission to Review*, pages 5 - 6.

[692] Law Society of NSW, *Submission to Law and Justice Review*, pages 3 - 5.

[693] ALA, *Submission to Law and Justice Review*, section 4.

[694] NSW Bar Association, *Submission to Law and Justice Review*, page 9.

[695] ALA, *Submission to Law and Justice Review*, page 32.

[696] *A confidential submission*.

Many of the NSW Bar Association's concerns relate to insurer decision-making and insurer conduct in relation to the categorisation of injuries as "minor injuries". The ALA considers that insurer decision-making in relation to "minor injury" is "*woeful*".[697] Insurer decision-making in the Scheme is considered elsewhere in this paper.

Both the ALA and the Law Society of NSW indicate that chronic adjustment disorder and DRE Category II spinal injuries should not be included in the definition of minor injury.[698]

Osteopathy Australia made a detailed submission on this question. It considers that "the Act glosses over complexities presented by" the injury classifications in the minor injury definition.[699] It makes recommendations as follows:[700]

(a) *that the Act be expanded to provide appropriate benefits to clients with spinal nerve root injuries (excluding radiculopathy) having gradual onset up to six months post injury;*

(b) *that the Act limit its definition of 'minor spinal nerve root injury' specifically to injuries with low level localised pain and no or limited impact for daily living activities;*

(c) *that the Act better differentiate spinal nerve root injury severity, moving away from the simplistic 'radicular and non-radicular' distinction. We suggest a new category be created for 'moderate injury'--- covering spinal nerve root injuries (excluding radiculopathy) that contribute to loss of movement, altered sensation, or changes in reflexes;*

(d) *that the Act better differentiate soft tissue injuries and move away from a blanket categorisation of these injuries as minor. We suggest a new category be created for 'moderate injury'--- covering soft tissue injuries that fail to improve or become progressively worse despite initial skilled clinical management; and*

(e) *the Act should not base psychological injury severity on whether a diagnostic label can be associated with symptoms. It should instead require psychological injuries be graded by qualified mental health professionals based upon their impact on client affect, attitude and function, diagnostic label notwithstanding. This change would support the growing number of clients with pain conditions and psychological symptoms that may not be able to be clearly fitted into a diagnostic box but are crucial to manage in recovery*.

There was also a suggestion made by medical stakeholders that, as we understand it, early intervention for people with a medium to high risk of poor recovery from a minor injury, and a corresponding categorisation, may be a way to more appropriately work towards a better outcome for those claimants. In addition, it was also suggested that the ability to access some form of care to *maintain* a claimant's functioning in addition to improving it, past the 26 week mark, may be appropriate to achieve the objectives of the Scheme.[701]

Limitations on weekly payments

The Review observes that the limitations on weekly payments are stronger for minor injuries than the limitations on benefits for treatment and care because there is no provision for weekly payments beyond 26

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[697] ALA, *Submission to Law and Justice Review*, page 3.

[698] ALA, *Submission to Review*, pages 5 - 6; Law Society of NSW, *Submission to Review*, page 6; ALA, Consultation Meeting.

[699] Osteopathy Australia, *Submission to Review*, page 5.

[700] Ibid, pages 2 - 3.

[701] Medical and Allied Health, Consultation Meeting.

weeks under any circumstances. In its Minor Injury Review, SIRA stated that, averaged across occupations, 76% of claimants with only minor injuries who were in paid employment before injury and received weekly payments after injury indicated a return to work within 26 weeks.[702] SIRA acknowledged that there is a gap in information concerning return to work after 26 weeks and that it is taking steps to gather relevant data.[703] In the meantime, it seems clear that the 26-week limit on weekly payments for persons with only minor injuries must limit achievement of Objective (b) to some extent.

As to whether the period for which weekly benefits are available for persons with minor injuries only, the ICA and Suncorp agree that 26 weeks is appropriate,[704] as, according to the ICA, it provides:[705]

> "*for greater focus on recovery and supports the timely resolution of minor injury claims, thereby reducing the length of time that an injured person needs to spend in the Scheme. This approach reflects the growing evidence which highlights that involvement in the compensation process is associated with poorer health outcomes. It is also consistent with the objective of the Scheme reform that the greatest proportion of benefits are directed to the more seriously injured*."

The Law Society considers that this period should be extended to 12 months for claimants who are not at fault, in tandem with the time for the liability decision being extended to 9 months. The period, according to the Law Society of NSW, should also extend where there is an ongoing PIC dispute.[706]

A confidential submission advocated for the position that all claimants should be entitled to 12 months of benefits. The availability of damages would still require an assessment of whether a claimant has a "minor injury".[707]

The ALA considers that such an extension requires an assessment of "what has to be cut to pay for any enhancement or increase in scheme benefits".[708]

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[702] SIRA, *Minor Injury Review*, page 27.

[703] Ibid.

[704] ICA, *Submission to Review*, page 11; Suncorp, *Submission to Review*, page 7.

[705] ICA, *Submission to Review*, page 11 (citations omitted).

[706] Law Society of NSW, *Submission to Review*, page 10.

[707] *A confidential submission*.

[708] ALA, *Submission to Review*, page 8.

Injured persons who are at fault

At-fault injured persons have significantly greater entitlements to support under the Scheme compared with the 1999 Scheme. However, strictly speaking, the cessation of statutory benefits at 6 months for at-fault injured persons cuts across Objective (a).

The ALA and the Law Society of NSW agree that statutory benefits for treatment and care for at-fault persons should be limited compared to injured persons who are not at fault.[709] Both stakeholders take this position on the basis that there is a finite pool of funds available to be disbursed through the Scheme, and that if a "rationing mechanism"[710] is to be used, fault is the appropriate one.[711] The ICA pointed out in a consultation meeting that the objectives of the Act do not distinguish between fault and no fault.[712]

The ICA and Suncorp Group Limited have previously expressed support extending statutory benefits for at-fault persons (with non-minor injuries) past 6 months.[713] The ICA suggests that this could be done by simply removing all limitations on statutory benefits for at-fault persons,[714] or extending the period of treatment and care benefits only.[715] In evidence given to the hearings of the Law and Justice Review, the NSW Bar Association appeared also to support extending statutory benefits for at-fault persons on the basis that it would be an inexpensive extension of the Scheme.[716]

The Law Society of NSW considers that the 6-month period for at-fault benefits is appropriate, on the basis that extending this period may not be "*feasible in the context of the current CTP insurance framework.*"[717] It contends that:[718]

> "*If increased numbers of at-fault people entered the Scheme, it is inevitable that disputes concerning minor injury, treatment and causation would increase. As timeframes for the cessation of benefits approach, it is foreseeable that insurer decisions regarding fault and liability would also be challenged in greater numbers.*
>
> *The Law Society is concerned that with only 12% of insurer internal reviews for minor injury decisions resulting in a decision in favour of the claimant, and extensive delays occurring in the PIC, particularly with regard to medical assessments, the Scheme's current framework is simply not equipped to handle the level of disputation that could occur.*
>
> *The Law Society's members are also well aware of the frequently deleterious psychological impact on many claimants who have been injured by the negligent actions of another who is shielded from personal liability for his or her actions by the role of the insurer and who may also*

[709] ALA, *Submission to Review*, page 6; Law Society of NSW, *Submission to Review*, page 6; Questions 11 - 14.

[710] ALA, *Submission to Review*, page 6.

[711] Ibid; Law Society of NSW, *Submission to Review*, page 6.

[712] ICA, Consultation Meeting.

[713] ICA, *Supplementary Submission to Law and Justice Review*, page 2; Suncorp, *Submission to Law and Justice Review*, page 1.

[714] ICA, *Supplementary Submission to Law and Justice Review*, page 3.

[715] Ibid; see also Suncorp, *Submission to Law and Justice Review*, page 1.

[716] Law and Justice Review, *Hearing Transcript*, 25 May 2021, page 48 (Ms Welsh).

[717] Law Society of NSW, *Supplementary Submission to Law and Justice Review*, page 1.

[718] Law Society of NSW, *Submission to Review*, page 7 (citations omitted).

be receiving benefits for his or her injuries. This impact is likely to increase if treatment benefits and/or weekly benefits continue beyond 26 weeks for those at fault."

The ICA, in its submission to the Review, noted that it considers the rationing of Scheme benefits subject to a range of many variables, and consider that this issues is a matter "for separate and detailed investigation".[719] It did note that extending benefits under the Scheme could affect the achievement of section 1.3 of the Act as it pertains to "affordability, sustainability, stability and predictability".[720]

Suncorp considers that statutory benefits for treatment and care and weekly benefits "*should be made available to all injured people regardless of fault for up to two years. However, the extension of benefits for up to two years should only apply to injured people who do not have a minor injury in accordance with the definition*" in the Regulation.[721]

Dr Chesterfield-Evans considers that at-fault drivers should "have the same benefits as not at fault drivers".[722]

There was a concern expressed by a representative at the medical and allied health consultation meeting that at-fault injured persons have no access to Lifetime Care, which means their treatment and care under the Scheme ceases after 6 months. This is difficult and can be disheartening for a treating practitioner, who may have to cease only recently commenced treatment.[723]

Similarly, the Road Trauma Support Group NSW expressed, as we understand it, a concern about the imposition of limitations on the amount of compensation available for families of persons killed who, despite not being the driver, are determined to be partially responsible.[724]

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[719] ICA, *Submission to Review*, page 7.

[720] ICA, *Submission to Review*, page 7.

[721] Suncorp, *Submission to Review*, page 6.

[722] A Chesterfield-Evans, *Submission to Review*, page 12.

[723] Medical and Allied Health, Consultation Meeting.

[724] Road Trauma Support Group NSW, Consultation Meeting.

Persons with restricted statutory benefits

The exclusion of statutory benefits for at-fault uninsured drivers or owners and for persons who commit a serious driving offence that relates to the accident are also not consistent with the plain terms of Objective (a).

The ALA submits that the provisions of section 3.37 of the Act have been interpreted in a way that operates unjustly in relation to persons who commit a serious driving offence (as defined in the Act).[725] This is because the (now-replaced) DRS is said to have applied section 3.37 in a way that did not require the driving offence to have any causative role in the accident concerned in order to satisfy the test that the offence be "related to the motor accident". If that is correct, then it is not clear whether that represents the correct application of section 3.37(3) of the Act which, on its face, appears to set out a necessary, but not a sufficient, condition for the offence to be related to the motor accident.

In any event, the ALA submits that the provisions excluding statutory benefits for persons who commit a serious driving offence create a punishment for the offence imposed by the civil law, and that the provisions therefore need to be calibrated carefully so as not to impinge unduly on the availability of statutory benefits for injured persons who are in need of treatment and care.[726] Certainly, these provisions advance a policy objective which is not any of those set out in the Act itself.

[725] ALA, *Submission to Law and Justice Review*, pages 38 - 40.

[726] Ibid, page 38.

Claims related to the death of a loved one

The ALA proposes that:[727]

> "*In relation to death claims, families should not be put through the wringer of the minor injury test for psychiatric impairment. Deem that for any parent who loses a child, a child who loses a parent or person who loses a spouse or sibling, there will be more than a minor injury without putting them to proof. This will not open any flood gates as it will still be necessary to establish loss in order to recover both statutory benefits and damages. If a person within this category loses a close relative and makes an adequate recovery with no ongoing psychiatric impairment, then there will be no need for treatment expenses, there will be no wage loss, and they will not have injuries over 10% WPI. The concession as to minor injury costs the insurer little, but extends some degree of dignity to the person concerned in not attaching a "minor injury" label to their situation*."

The adoption of such a proposal would appear to be supported by a confidential submission to the Review by an individual who was in the position contemplated by the ALA above. A similar issue was raised by a group of stakeholders in this position during a consultation meeting.[728] That group considers that extended family members and close partners should be entitled to support through the CTP Scheme.[729]

The Road Trauma Support Group NSW considers that the provision of funeral expenses under Division 3.2 should be reviewed, on the basis that the "reasonable" expenses provided can be inadequate, and can vary among insurers and claims. One suggestion was the introduction of a statutory amount available for funeral benefits to enhance certainty.[730]

The principle of early intervention in relation to grief and trauma for families affected by road trauma was emphasised. The Road Trauma Support Group NSW suggested that policies be refined to "*ensure claimants have access to the best professional support at the earliest possible time, unaffected by administration requirements*". It also recommended consideration of the Scheme funding a pool of Trauma Support Specialists for those affected.[731]

The Road Trauma Support Group NSW considers that the Scheme's "definition of injury and underlying themes of maximising return to work" are better aligned with physical injury but do not work as well in relation to "psychological, mental and emotional" injuries after the death of a loved one.[732]

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[727] ALA, *Submission to Review*, page 5.

[728] Road Trauma Support Group NSW, Consultation Meeting.

[729] Ibid.

[730] Ibid.

[731] Ibid.

[732] Ibid.

CTP Care

LTCSA is tasked with administering the CTP Care program. LTSCA proposes five amendments to the Act that would assist in this role:[733]

(i) *prescribing circumstances when treatment and care determinations made by the relevant insurer and/or the Personal Injury Commission (PIC) may be re-assessed;*

(ii) *including a limitation period in which treatment and care expenses for minor injuries can be paid;*

(iii) *extending the Nominal Defendant Fund to cover any outstanding payments to be made by a licensed insurer that experiences insolvency;*

(iv) *preventing recoveries from third parties on the Motor Accidents Treatment and Care Benefits Fund (MAITCBF);*

(v) *extending the timeframe for determining treatment and care where the claimant has not had contact with the relevant insurer within the past 12 months.*

In a consultation meeting with LTCSA, it was explained in relation to (i) above that it was LTCSA's understanding, as we understood it, that the PIC can make binding decisions on insurers and claimants, particularly in relation to medical assessments, with only limited circumstances where those decisions would be reviewable. In the context of a lifetime scheme, it contends, it is important that these decisions are capable of being changed as a person's life and medical needs and circumstances change. It is of the view that the Scheme in its current form is focused on acute injuries and early stages of claims, and could be better articulated in respect of long term and lifetime injuries.[734]

[733] LTCSA, *Submission to Review*, pages 4 - 6.

[734] LTCSA, Consultation Meeting.

SIRA's power to impose a civil penalty

On SIRA's ability to impose a civil penalty on an insurer under section 9.10 of the Act, a number of stakeholders held the view that it was peculiar that one of the "committee" members tasked with issuing letters of censure or imposing civil penalties on insurers was a member of the Insurance Council of Australia. Others considered it out of the ordinary that the regulator be given the direct power to impose a civil penalty, in comparison with the Commonwealth's approach of giving the relevant regulator (for example, the Australian Securities and Investment Commission) the ability to apply to a court for a civil penalty to be imposed by the court.[735] The ICA supports this process; it considers there could be scope to simplify the process for convening the committee to facilitate SIRA's exercise of its regulatory function.[736]

[735] IRO, Consultation Meeting; ALA, Consultation Meeting; Law Society of NSW, Consultation Meeting.

[736] ICA, Consultation Meeting.

Road safety

Dr Richard Tooth considers that an additional objective should be introduced to the effect of "to encourage safe road use".[737] In a consultation meeting, Dr Tooth made the point, as we understand it, that if such an objective was introduced, SIRA may have the flexibility to move in the direction of a free rating system.[738]

The Road Trauma Support Group NSW considers that SIRA an interest in identifying and managing risks, and that on that basis SIRA and the CTP insurers could invest in road safety initiatives. This could be through expanded support for the Community Road Safety Fund, administered by the Centre for Road Safety. It also considers that SIRA should have an advocacy and strategic role in road safety.[739]

When the idea of introducing an objective to encourage safe road use was raised with other stakeholders, other stakeholders such as private individuals aligned with the Law Society of NSW were concerned that as SIRA has little to do with road safety, and the Scheme is privately underwritten, such an objective may add more complexity without addressing existing issues within the Scheme.[740] Other stakeholders considered that road safety has not traditionally been within SIRA's ambit, and there was a concern that steps taken to achieve such an objective may divert resources from the Scheme's core purpose of ensuring treatment and care for injured persons.[741] Others questioned whether doing so could have any impact on the prevention of accidents.[742]

LTCSA recommends that the "*Scheme objectives be broadened to include an objective to minimise loss and maintain health and function where early recovery cannot occur*."[743]

A confidential submission received by the Review recommended that an objective that "*Persons injured in motor accidents are fairly compensated for their historical and future losses and expenses*" should be included. This submission also recommended strengthening the wording of the objectives in a more general sense.

[737] R Tooth, *Submission to Review*, page 9.

[738] R Tooth, Consultation Meeting.

[739] Road Trauma Support Group NSW, Consultation Meeting.

[740] Law Society of NSW, Consultation Meeting.

[741] ICA, Consultation Meeting.

[742] ALA, Consultation Meeting.

[743] LTCSA, *Submission to Review*, page 2.

APPENDIX B: DISCUSSION PAPER

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

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[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.

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[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]

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[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

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[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:

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[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

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[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]

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[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?

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[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

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[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

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[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.

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[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

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[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.

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[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]

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[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]

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[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.

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[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]

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[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]

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[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.

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[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]

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[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

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[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

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[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

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[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?

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[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

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[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

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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

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