Standing Committee on Law and Justice 2022 Review of the Compulsory Third Party Insurance and Lifetime Care and Support Schemes

10 October 2022

SUBMISSION | NEW SOUTH WALES

BAR ASSOCIATION

Promoting the administration of justice

The NSW justice system is built on the principle that justice is best served when a fiercely independent Bar is available and accessible to everyone: to ensure all people can access independent advice and representation, and fearless specialist advocacy, regardless of popularity, belief, fear or favour.

NSW barristers owe their paramount duty to the administration of justice. Our members also owe duties to the Courts, clients, and colleagues.

The Association serves our members and the public by advocating to government, the Courts, the media and community to develop laws and policies that promote the Rule of Law, the public good, the administration of and access to justice.

The New South Wales Bar Association

The Association is a voluntary professional association comprised of more than 2,400 barristers who principally practice in NSW. Currently, 423 of our members report practicing in the areas of common law and personal injury. We also include amongst our members judges, academics, and retired practitioners and judges.

Under our Constitution, the Association is committed to the administration of justice, making recommendations on legislation, law reform and the business and procedure of Courts, and ensuring the benefits of the administration of justice are reasonably and equally available to all members of the community.

This submission is informed by the insight and expertise of the Association's Common Law Committee.

Contents

A. Executive Summary and Recommendations

1. The NSW Bar Association (**the Association**) thanks the NSW Legislative Council's Standing Committee on Law and Justice (**the SCLJ**) for the invitation to comment on the 2022 Review of the Compulsory Third Party Insurance and Lifetime Care and Support Schemes.

2. At the outset, the Association draws attention to the following figures published by Ernst & Young in August 2022, which relate to actual versus expected claims experience between December 2021 and June 2022 (**the relevant period**):[1]
    a. Statutory benefit claims reported during the relevant period were expected to be 1,174. The actual number of statutory benefit claims reported was 717. This is a difference of 457 claims or 39% less than expected.[2]
    b. Statutory benefit claim payments during the relevant period were expected to be $153.4 million. The actual amount paid out was $104.4 million. This is a difference of $49 million or 32% less than expected.[3]
    c. Claims reported for damage in cases where whole person impairment (**WPI**) was >10% during the relevant period were expected to be 638. The actual number of claims reported was 358. This is a difference of 280 claims or 44% less than expected.[4]
    d. Claims reported for damages in cases where WPI was ≤10% during the relevant period was expected to be 667. The actual number of claims reported was 203. This is a difference of 464 claims or 70% less than expected.[5]

3. The Association also notes that 60% of not at fault claims are assessed as involving minor injury.[6] The Compulsory Third Party Insurance Scheme (**CTP Scheme**) was designed on the basis that this figure would be 50%.

4. In the Association's opinion, each of these figures, and the figures at 2(d) in particular, indicate that the CTP Scheme is significantly underperforming. The figures in 2(c) and (d) also suggest that the current test for minor injury is excluding too many claims from the system.

5. The additional 10% of not at fault claims which are presently being assessed as involving minor injury is preventing an additional 10% of accident claimants, whom the CTP Scheme intended to have a right to receive damages, from pursuing their entitlement to damages and will thereby

[1] Ernst & Young, *2017 CTP Scheme: Quarterly Actual Monitoring – 30 June 2022 data*, 15 August 2022.
[2] Ibid p. 26.
[3] Ibid p. 27.
[4] Ibid p. 31.
[5] Ibid p. 31.
[6] Ibid pp. 17-19.

be causing significant injustice. The Association believes that this injustice is a direct result of an unfair minor injury test.

6. The Association advocates for the SCLJ to make the following recommendations in order to improve the CTP Scheme:
    a. Recommendation 1 – that the State Insurance Regulatory Authority (**SIRA**) review the definition of minor injury in relation to physical injuries including costing the impact of the following amendment to the definition:
        "A soft tissue neck and back injury assessed as causing a less than 5% whole person impairment is minor."
    b. Recommendation 2 – that the *Motor Accident Injuries Act 2017* (NSW) (**MAI Act**) and *Motor Accident Compensation Act 1999* (NSW) (**MACA**) be amended to reflect the workers compensation legislation by providing for resolution of disputes involving questions of causation to be determined as a legal issue after a hearing on the merits during conciliation/arbitration or mediation, with medical issues determined subsequently as medical assessment matters.
    c. Recommendation 3 – that legal costs for statutory claims under the MAI Act should be commensurate with costs paid in comparable disputes under the workers compensation scheme.
    d. Recommendation 4 – that the Personal Injury Commission (**the PIC**) be empowered to undertake merits review concerning disputes as to treatment and care under the Lifetime Care and Support Scheme and CTP Care.

7. The Association considers that the Government's objective of making premiums affordable has been met in the CTP Scheme, with the current CTP average premium in New South Wales being $483.

8. The Association submits that any further changes concerning premiums should restore the balance between benefits and insurer profit in line with the stated objectives of the 2017 reforms to the CTP Scheme.

9. Future evaluations of the performance of the CTP Scheme should focus on delivering both the stated objectives and the legislative objectives relating to the payment of benefits under the Scheme, being:
    a. To provide the fairest compensation regime possible consistent with maintaining the present premium;
    b. To ensure the majority of premium is paid to the injured with an emphasis on the most seriously injured;

c. To ensure the restriction on claims for damages is confined to injuries which are genuinely minor in nature without restricting or removing the right to claim damages for those with moderate or serious injuries;
d. To equip the regulator with sufficient resources to monitor insurer behaviour so that claims for statutory benefits are not rejected unreasonably and unrepresented claimants are not discouraged from exercising their rights to claim compensation or damages due to insurer behaviour. We note that currently 77.9% of claimants do not have legal representation;[7]
e. To require CTP insurers, as receivers of public money that is compulsorily levied, to act in all cases in a way which promotes the quick, cost effective and just resolution of disputes; and
f. To equip the regulator with sufficient resources to perform its statutory function to undertake a genuine, open and widespread consultation for the purpose of conducting an ongoing review of the minor injury definition. This should include seeking feedback from non-legally represented claimants who have left the CTP Scheme.

10. The Association expands on these recommendations further below.

[7] State Insurance Regulatory Authority, *2017 CTP Scheme Open Data: Claims by Legal Representation (New CTP) – 12 months*, <https://www.sira.nsw.gov.au/CTP-open-data>.

B. Proposed Recommendations

Recommendation 1

That SIRA review the definition of minor injury in relation to physical injuries including costing the impact of the following amendment to the definition:

> ***"A soft tissue neck and back injury assessed as causing a less than 5% whole person impairment is minor."***

Issues with the current minor injury definition

11. In its 2020 Review of the CTP Scheme, the SCLJ proposed as part of Recommendation 1:

> *That the current statutory review of the Motor Accident Injuries Act 2017 closely consider the following issues for reforms to the scheme:*
>
> …
>
> *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...* [8]

12. In its Review, the SCLJ summarised the submissions of the NSW Bar Association (at Attachments 1 and 2) on this point as follows:

> *The NSW Bar Association outlined a number of examples in its submission of problems encountered in relation to the minor injury definition, including insurers not accepting the opinion of a treating doctor, and claims officers and rehabilitation providers attending medical consultations between doctors and a claimant, undermining doctor patient privilege. It also highlighted that 60 per cent of claims are closed after 26 weeks as 'minor injuries' whereas original predictions made by actuaries had this figure at 50 per cent. The NSW Bar Association, in particular, called for the whole person impairment test to be reduced from 10 per cent to 5 per cent.*[9] (footnotes omitted)

13. In its Response to the 2020 Review, the NSW Government expressly supported the SCLJ's recommendation and noted that Clayton Utz and Deloitte considered that recommendation as part of the Statutory Review of the MAI Act (**the Clayton Utz Review**).[10]

---

[8] NSW Legislative Council's Standing Committee on Law and Justice, *Report No. 77: 2020 Review of the Compulsory Third Party Insurance Scheme,* July 2021, p. vii.

[9] NSW Legislative Council's Standing Committee on Law and Justice, *Report No. 77: 2020 Review of the Compulsory Third Party Insurance Scheme,* July 2021, p. 8, referring to NSW Bar Association, *Submission to the 2020 Review of the Compulsory Third Party Insurance Scheme*, 10 November 2020 and NSW Bar Association, *Supplementary Submission to the Standing Committee on Law and Justice's 2020 Review of the Compulsory Third Party Insurance Scheme*, 10 December 2020.

[10] NSW Government, *Government Response to the Report of the Legislative Council's Standing Committee on Law and Justice on the 2020 Review of the Compulsory Third Party Insurance Scheme.*

14. In the Clayton Utz Review, the independent reviewer made a number of recommendations in relation to the minor injury framework and recognised the importance of ensuring that the scope of the minor injury definition is appropriately balanced against the needs of injured persons who are affected by it.[11]

Subsequent correspondence between the Association and the SCLJ regarding Recommendation 1 of the 2020 Review of the CTP Scheme

15. On 30 August 2021, the Association wrote to then Committee Chair, the Hon. Wes Fang MLC, requesting clarification on Recommendation 1 of the 2020 Review of the CTP Scheme (see Attachment 3). Specifically, the Association submitted:

> *Having reviewed the Report, it seems that there is an inadvertent error in the second bullet point of Recommendation 1, which reads: "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".*
>
> *Given the nature of the discussion on those matters in the body of the Report (eg. at paragraphs [2.8] to [2.22]), it appears that the second reference in the above sentence should instead be to "**non-minor**" injuries.*
>
> *That is, if the intention of the recommendation is that the statutory review should consider how the 'minor injury' definition can be amended to avoid capturing those who do not have genuinely minor injuries (ie. those who have non-minor injuries), the Association respectfully submits that the second bullet point of Recommendation 1 should read:*
>
> > *That the current statutory review of the Motor Accident Injuries Act 2017 closely consider the following issues for reforms to the scheme:*
> > *…*
> > *how the minor injury definition can be amended to ensure that it does not ~~exclude~~ **include** those with genuine **non-**minor injuries, including in relation to psychological claims.*

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

16. On 7 September 2021, the Association received a response from the Committee Chair advising that the issues raised by the Association could be pursued at the time of the next review (see Attachment 4).

The unfair consequences of too many minor injury determinations

17. As noted above, 60% of not at fault claims are presently being assessed as involving minor injury.

18. The original assumption was that there would be 6,000 claims for damages each year.[12] In July 2020, the figure was revised down to between 4,400 and 3,685. In June 2022, it was further reduced to between 2,800 and 3,600. This is close to half of the original assumption.

19. The impact of denying benefits to the most seriously injured under the current broad definition of minor injury is stark. The shift from a 50% to a 60% minor injury classification has the following effect:

    a. 1,000 minor injury claims at $6,750 each (Ernst & Young, June 2020 – average of $4,500 – $9000) = $6,750,000 ($6.75 million), as opposed to
    b. 1000 non-minor injury claims at $100,000 = $100,000,000 ($100 million).

20. This considerable difference has profound and unfair consequences for injured persons. Further, while the reality is that some of those non-minor injury claims would be above the 10% WPI threshold, on any account, it represents an extraordinary discrepancy in expected versus actual experience.

Current CTP Scheme performance on a comparison of actual versus expected claims numbers and payments

21. The Association refers again to the figures published by Ernst & Young in August 2022 which relate to actual versus expected claims experience in the CTP Scheme between December 2021 and June 2022 (as highlighted in paragraphs 2 – 3 above).

22. The Ernst & Young figures indicate that the CTP Scheme is significantly underperforming. In the Association's view, the figures clearly suggest that the current test for minor injury excludes too many claimants from the Scheme and is thereby likely to be causing significant injustice by preventing an additional 10% of accident claimants from pursuing their entitlement to damages.

[12] Ernst & Young, *Cost Regulation Costing*, 6 July 2017, p. 9.

23. This position is reinforced by the fact that claim payments for damages in the December 2021 – June 2022 period for injuries with <10% WPI were $28.7 million, or 58%, less than expected.[13]

Clayton Utz assumed that SIRA would undertake another review of the minor injury definition

24. The Clayton Utz Review identified that the objective outcomes of the minor injury test come 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.[14]

25. In its review of the minor injury framework, the independent reviewer also recognised that the minor injury definition will do its work imperfectly and that some injured persons will lose support that they actually still need.[15]

26. Clayton Utz felt that they were not in a position to examine the definition of 'minor injury' from a technical point of view and it was assumed that SIRA would undertake another review of the minor injury definition.[16] The Review concluded:

> *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.*[17]

27. In the Association's opinion, it is evident that Clayton Utz were sufficiently concerned by the identified discrepancies arising from the minor injury definition to highlight their assumption that, given those discrepancies, SIRA would review the definition.

28. The Association urges SIRA to act on this assumption and the significant concerns underlying it by reviewing the definition of minor injury as a matter of priority.

29. Recommendation 34 of the Clayton Utz Review was that the Minister consider the making of an amendment to the regulations to remove 'adjustment disorder' from the definition of

[13] Ibid p. 32.
[14] Clayton Utz, *Report: Statutory Review of the Motor Accident Injuries Act 2017*, 22 September 2021, p. 84.
[15] Ibid Section 3.9.4.
[16] Ibid p. 86.
[17] Ibid p. 87.

'minor injury'. This recommendation has been embraced by the NSW Government. It is clear that further work must be done to define minor injury in the context of physical injury to provide the same fairness: that is, the definition of minor injury in relation to physical injury should only capture those injuries which genuinely resolve within 6 months after the motor accident.

30. The Association has expressed particular concerns about the categorisation of some soft tissue neck and back injuries as minor since the original design of the MAI Act in 2016.

31. With the benefit of several years' experience of the minor injury definition at work, the Association remains of the view that its proposed amendment to the definition would solve many of the current problems in this area, principally:

a. It may eliminate, and would discourage overuse by insurers of arguments relating to, the aggravation of pre-existing degenerative change;
b. It would re-establish the test of causation in the MAI Act in relation to WPI which is consistent with the common law position for the purpose of determining the nature and extent of an injury;
c. It would be a test based on the *American Medical Association Guides to the Evaluation of Permanent Impairment, Fourth Edition* (1995) (**AMA 4 Guides**), which are a central feature of the MAI Act and which are better understood and widely applied in comparison with the unique definition in the MAI Act; and
d. It would move the dispute to a position where an injured person will at least have the benefit of a medical assessor determining the nature of the injury, as opposed to being placed at an unfair disadvantage in dealing, often directly, with a well-resourced, experienced insurer at an early stage after an injury.

The importance of collecting and publishing data for assessing the performance and operation of the CTP Scheme

32. The Association considers greater transparency as to the CTP Scheme's operation is required to support the statutory objectives of the CTP Scheme.[18]

33. The 2017 CTP Scheme Open Data page on the SIRA website records gross amounts paid under the CTP Scheme to date. There is no doubt that premium and claims numbers are well within Scheme design objectives.

[18] In particular to ensure the collection and use of data to facilitate the effective management of the compulsory third-party insurance scheme as per section 3.1(2)(h) of the MAI Act.

34. The following information, which could be readily gleaned from data presently collected by SIRA, would provide an insight into how the Scheme is operating:

a. How many current claims for statutory benefits are open on each CTP insurers' books;
b. How many current open files include a concession or determination that an injured person has exceeded the 10% WPI threshold;
c. How many current and open claims for damages each insurer has; and
d. How many current claims involve ongoing weekly benefits in the statutory benefits scheme.

35. This is data which the Association believes SIRA would have and which it submits should be made publicly available so as to put the overall figures into context and permit an understanding of whether claim numbers are escalating or whether they have stabilised.

36. lt is not sufficient for broad cumulative figures to be provided without the detail essential for a proper understanding of the Scheme's operation. The public are entitled to know how the Scheme is working, particularly well after the three year "honeymoon period", a statutorily recognised point at which it was considered that a reliable assessment of the Scheme's performance would be possible. In our view, the fewer claims under the Scheme than the modelling predicted can no longer be explained on the basis of the honeymoon period: three years was considered to be the time at which Scheme performance would be sufficiently indicative to justify formal review.

37. SIRA and the CTP insurers may seek to draw a comparison with a slow uptake in claims following the introduction of the MACA in relation to damages claims. In the Association's view, this is not a proper analogy.

38. The MACA saw the introduction for the first time of the 10% WPI threshold which took some time for the legal profession to understand. This has not been a barrier to claims under the MAI Act which has adopted the same approach to thresholds for damages claims as the MACA.

39. If damages claims are significantly reduced, as they appear to be, there must be some other explanation. The obvious factors include:

a. A definition of 'minor injury' which captures more serious injuries, thereby removing the right to claim damages;
b. The effective exclusion of the legal profession from the process;
c. The imbalance of power in favour of insurers; and

d. The lack of knowledge on the part of self-represented claimants regarding their legal rights and the value of their claims.

Recommendation 2

That the MAI Act and the MACA be amended to reflect the workers compensation legislation by providing for resolution of disputes involving questions of causation to be determined as a legal issue after a hearing on the merits during conciliation/arbitration or mediation, with medical issues determined subsequently as medical assessment matters.

40. The Clayton Utz Review considered the current claim and dispute resolution framework in the MAI Act, and the following policy objective in Section 1.3(2):

> *Objective g) To encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes.*

41. The Association regards the model for medical assessment under the workers compensation scheme as far preferable to the current processes under the MAI Act. Where there is a dispute about causation of an injury, the Workers Compensation Dispute Resolution Pathway works more efficiently and finalises claims in a more satisfactory way than similar disputes under the MAI Act.

42. Further, the workers compensation system provides a right of access to an independent tribunal for the purpose of determining the legal issue of causation. This affords an injured person and an insurer the opportunity to test the evidence at a hearing, as well as a right of review. Once that process has concluded, the medical assessor will determine the extent or degree of WPI, the need for treatment, or other medical issues.

43. By contrast, and as previously highlighted by the Association:

> *Under the MAI Act, there is no early identification of the issues which may require determination as the claim proceeds. Issues of injury, aggravation of pre-existing change or causation are rolled up into the definition of 'minor injury' (s 1.6 MAI Act) or into the question of whether there is a whole person impairment greater than 10% (s 4.11 MAI Act). It is then a matter for a medical assessor to determine all issues which arise, with the result that a party, particularly those without legal representation, have had a 'hearing' without ever understanding the issues to be determined. That is obviously unsatisfactory and gives rise to*

undue complication involving administrative law review or further medical assessment, assuming that the injured person is capable of pursuing either of those remedies.[19]

44. To summarise, causation of injury is decided as a legal issue under the workers compensation system, whereas it is resolved as a quasi-medical issue, with complex legal tests applied by medical practitioners, under the motor accident scheme. Under the latter scheme, legal issues are generally incompletely understood and imperfectly applied by those performing medical assessments.

45. Members of the Association have also observed that medical disputes in the motor accident context are more prolonged and often unnecessarily expensive, placing a substantial burden on the medical assessment system as a whole under the MAI Act.

46. Proof of the disparity between the systems lies in the vastly greater number of successful administrative law challenges to medical assessment disputes brought in the Supreme Court in motor accident cases than in workers compensation cases.

47. In the Association's view, applying the Workers Compensation Dispute Resolution Pathway to similar disputes under the MAI Act would be fairer and more efficient.

Recommendation 3

Legal costs for statutory claims under the MAI Act should be commensurate with costs paid in comparable disputes under the workers compensation scheme

Access to legal advice and representation

48. The public should be able to have confidence that state agencies administering motor accidents injury compensation and the Scheme as a whole are accessible and transparent, and will afford the injured a fair opportunity to uphold their lawful rights.

49. The Association considers that the current CTP Scheme is failing to care for or adequately support the injured, leaving them to fend for themselves against insurance companies and Scheme agents who have access to lawyers with specialist expertise. The legislation is extraordinarily complex, involving cross references to other pieces of legislation, regulations, claims and medical guidelines.

[19] NSW Bar Association, *Submission: State Insurance Regulatory Authority Consultation on the McDougall Review, COVID-19 and future opportunities for personal injury schemes*, 4 November 2021.

50. The Association believes that the CTP Scheme has become increasingly technical, unnecessarily bureaucratic and difficult to navigate without legal assistance. The public are not adequately informed of their rights, including the right to seek legal advice. The Association is concerned that the Scheme is presented, including on SIRA's website, as one not requiring a lawyer, notwithstanding that, on any view, it is a complex legislative regime. Victims are actively encouraged to seek to resolve the matter themselves, resulting in increased stress and emotional strain, which frequently results in an unfair outcome. The Association recommends that SIRA's public messaging be altered to direct and encourage claimants to seek legal advice.

Prescribed legal costs

51. Without reasonable, adequate remuneration being provided to legal representatives, the MAI Act cannot deliver a fair system for motor accident victims. There is currently no equality of arms before the PIC, in part because claimants and potential claimants – who are not legally trained – are left unrepresented in the face of legally well-resourced insurers.

52. Lawyers are paid $1,600 for all work performed in relation to a Dispute Resolution Service dispute for statutory benefits. The $50,000 and $75,000 no contracting out provisions are also operating too harshly in many cases. SIRA modelling in July 2017 suggested that there would be $130 million in non-contracted out legal costs in the statutory scheme per annum, and $258 million in common law costs per annum. It is possible for a lawyer to provide a service, which, after disbursements, can mean that most professional fees are written off. These limitations are unsustainable from the Association's perspective.

53. The paucity of legal costs in the CTP Scheme results in the vast majority of claimants being unrepresented, impacting adversely on the Scheme's overall performance. Most decisions, some of them determinative of wider rights such as the entitlement to damages, are made in the absence of a claimant having legal advice. In most cases, no lawyer protecting the claimant's interests will ever see these decisions. Claimants then leave the Scheme, assuming they have been paid all of their entitlements and dealt with fairly. If claimants have been dealt with fairly, it must follow from data as to the proportion of claimants' legal costs under the Scheme (see below at paragraph 56) that the Scheme is not performing as intended. If they have not been dealt with fairly, the justification for the Scheme (a new era of insurer behaviour) is absent and the Scheme is not performing as intended.

Incorrect assumptions underlying current prescribed legal costs

54. Current legal costs were determined by actuarial assumptions made in 2017 by Ernst & Young. As discussed above, these actuarial assumptions have proven to be wholly inaccurate, both as to the number of claims, the number of disputes and the number of disputes which would involve lawyers in the statutory benefits scheme.

55. In May 2021, Ernst & Young revised its premium assumptions.[20] The total assumed legal expenses (being statutory benefit costs and scale costs in claims for damages) were estimated at $274 million per annum.

56. The Scheme has been running for almost five years and total legal costs are only $95M for the past 12 months. Almost two thirds of this figure comprises insurance company costs. Claimants' legal costs are only $32.7 million of the total of $95 million. It is acknowledged that this figure has increased significantly over the past three years, but it is still only a third of the assumed amount each year and most of it is being paid to insurer's representatives.

57. There is clearly scope for increasing scale fees for legal services to a realistic level, which would benefit the operation of the Scheme by providing injured persons with recourse to proper legal advice. This is in contrast to the current situation where the scale costs in the statutory Scheme are unrealistically low, to the point that it is not viable to provide legal services in many cases.

58. The Association strongly recommends that the present disparity of legal representation of parties to disputes be rectified by a significant increase in prescribed fees for legal services, particularly in relation to statutory benefits. Any such increase should be at least commensurate with fees available under the workers compensation scheme.

Recommendation 4

The PIC be empowered to undertake merits review concerning disputes as to treatment and care under the Lifetime Care and Support Scheme and CTP Care

59. At present, the only avenue for review from a decision of an Assessor or Review Panel under the Lifetime Care and Support Scheme is by way of administrative law review proceedings in the Supreme Court of NSW. A review of the relevant cases discloses that this avenue is not being utilised.

[20] Ernst & Young, *Review of Dispute Projections for 2017 CTP Scheme,* State Insurance Regulatory Authority, May 2021.

60. The Association believes that this is because there is no right to legal representation in such a claim under the MAI Act and there is no provision for legal costs. While legal representation and legal costs are both available under the review of an administrative decision in the Supreme Court of NSW if a party is successful, the Association considers it to be highly unlikely that an unrepresented person would pursue that path or understand that is available.

61. The PIC is the appropriate forum for those disputes to be ventilated where a hearing can take place on the merits with some provision for legal costs.

62. At present in relation to CTP care, claims in which there is an ongoing entitlement to treatment will be entering that part of the Scheme later this year. Some may already have made the transition. At present there is no visibility as to:

    a. What is being paid under the MAI Act for care (as opposed to treatment); and
    b. How many people are receiving the benefit of care (and how many are not).

63. This is an area in which a thorough review is required and action needed to provide an accessible pathway of review of insurers' decisions. Again, the PIC is the appropriate forum for disputes arising out of that aspect of the Scheme to be resolved.

C. The NSW Bar

64. The Association is a voluntary professional association comprised of more than 2,400 barristers with their principal place of practice in NSW.[21] Currently, 423 of our members reportedly practice in the areas of common law and personal injury.[22] The Association also includes amongst its members judges, academics, and retired practitioners and judges. The Association is committed to promoting the public good in relation to legal matters and the administration of justice.[23]

65. Barristers are independent specialist advocates,[24] both in and outside of the courtroom.[25] Barristers owe their paramount duty to the administration of justice.[26]

66. The Association can speak with experience to issues affecting the performance and operation of the state's Compulsory Third Party Insurance Scheme. This submission reflects the expertise, experience and concerns of the Association's members including through the following initiatives.

67. The Association would be pleased to assist the Standing Committee on Law and Justice with any questions it may have, through oral or further written submissions. Please contact Lucy-Ann Kelley, Policy Lawyer, at , if you would like any further information or to discuss this submission.

---

21 NSW Bar Association, *Statistics*, as at 6 October 2022 <https://www.nswbar.asn.au/the-bar-association/statistics>.

22 Ibid.

23 NSW Bar Association, *New South Wales Bar Association Strategic Plan 2021-25* <https://nswbar.asn.au/uploads/pdf-documents/SP2021.pdf>.

24 *Barristers' Rules* r 4(c).

25 See *Barristers' Rules* r 11(c)(d).

26 *Barristers' Rules*, rr 4(a), 23.

Annexures

1 NSW Bar Association, *Submission to the 2020 Review of the Compulsory Third Party Insurance Scheme*, 10 November 2020

2 NSW Bar Association, *Supplementary Submission to the Standing Committee on Law and Justice's 2020 Review of the Compulsory Third Party Insurance Scheme*, 10 December 2020

3 NSW Bar Association, Letter to the Hon. Wes Fang MLC, Chair of the Standing Committee on Law and Justice, *Report No 77: 2020 Review of the Compulsory Third Party Insurance Scheme – Clarification on Recommendation 1*, 30 August 2021

4 The Hon. Wes Fang MLC, Chair of the Standing Committee on Law and Justice, Response to the NSW Bar Association's letter of 30 August 2021, 7 September 2021

Submission No 8

INQUIRY INTO 2020 REVIEW OF THE COMPULSORY THIRD PARTY INSURANCE SCHEME

Organisation: New South Wales Bar Association

Date Received: 10 November 2020

SUBMISSION | NEW SOUTH WALES

BAR ASSOCIATION

2020 Statutory Review of the Compulsory Third Party Insurance Scheme

10 November 2020

Promoting the administration of justice

The NSW justice system is built on the principle that justice is best served when a fiercely independent Bar is available and accessible to everyone: to ensure all people can access independent advice and representation, and fearless specialist advocacy, regardless of popularity, belief, fear or favour.

NSW barristers owe their paramount duty to the administration of justice. Our members also owe duties to the Courts, clients, and colleagues.

The Association serves our members and the public by advocating to government, the Courts, the media and community to develop laws and policies that promote the Rule of Law, the public good, the administration of and access to justice.

The New South Wales Bar Association

The Association is a voluntary professional association comprised of more than 2,400 barristers who principally practice in NSW. We also include amongst our members Judges, academics, and retired practitioners and Judges.

Under our Constitution, the Association is committed to the administration of justice, making recommendations on legislation, law reform and the business and procedure of Courts, and ensuring the benefits of the administration of justice are reasonably and equally available to all members of the community.

This Submission is informed by the insight and expertise of the Association's members, including its Common Law Committee.

Contents

1. Executive Summary

1. Thank you for the opportunity for the New South Wales Bar Association (**the Association**) to make submissions to the Standing Committee on Law and Justice (**the Committee**) 2020 Review of the Compulsory Third Party Insurance Scheme.

2. This review is timely. It is approaching the third anniversary of the commencement of the *Motor Accident Injuries Act 2017* (NSW) (***MAI Act***) and the end of the three-year transition period.

3. Section 11.13 of the *MAI Act* provides that the legislation must be reviewed as soon as practicable after the period of three years from commencement and a report of the outcome of the review is to be tabled in each House of Parliament within 12 months.

4. The Association has maintained its engagement with the State Insurance Regulatory Authority (**SIRA**) in relation to the operation of the Compulsory Third Party (**CTP**) Scheme (**the Scheme**) generally, and more particularly the progress of the *MAI Act*. In 2017 the value of CTP insurance for those injured on the road was substantially reduced based on actuarial claims made by the government. The then existing scheme was said to be "inefficient" as it put less than 50% of the premium collected into the hands of the injured. However, the Association has consistently raised concerns that the new Scheme has performed even worse. As outlined in this submission, overall figures indicate that barely 5% of premium dollars are now being received by injured claimants under the *MAI Act*.

5. By way of contrast, CTP insurers have kept over $8 billion dollars, with no chance of clawing back any super profits for years to come, if at all.

6. The Minister claimed the new Scheme would herald a change in insurer behaviour, where claims would be accepted based on a straightforward exchange of information. It was said that the new system would be so easy for an injured person to navigate that they would no longer need a lawyer.

7. Why then are the CTP insurers retaining over 90% of premiums? How has that money been allocated? How much of that premium do the insurers have the benefit of for investment purposes?

8. First, there is no evidence that insurer behaviour has changed. Under the previous *Motor Accidents Compensation Act 1999* (NSW), insurers were rejecting and closing as many claims as possible because claims officers were set targets for the number of claims they should be closing and bonuses within insurers were paid based on the number of closed claims, irrespective of the legitimacy of closing any given claim. It is unclear whether that practice continues. In any event, whereas the Minister identified the exchange of information as the bedrock of the new Scheme, in practice insurers regularly retain experts rather than relying on the primary information provided in support of a claim.

9. Second, insurers have significant resources. Three in four people injured in a motor accident do not have a lawyer, and injured people are told that they do not need one. Because of the Scheme's complexity, most people will struggle to understand their rights and entitlements. This means

many will not appreciate that those rights are worth fighting for.

10. Third, there are so many friction points in the system that the insurer has multiple opportunities to reject a claim. Their resources extend to commonly using traffic reconstruction experts and interviews with police officers to decide that an injured person is at fault for the accident, forensic accountants to reject a claim for loss of income, and medical specialists to overrule a treating doctor's recommendations. Each of these areas of dispute would be time consuming and wearing for anyone but even more so for a person who has been injured and is without legal representation.

11. Thus, the opinions (including those of general duties police) are presented to claimants, who overwhelmingly have no legal representation and do not appreciate the legal avenues available as final. Another claim file is closed and the bonus flows to the insurer and its staff. Each of these decisions will be communicated by service of a letter with an explanation for denying the claim, such as "the police have decided that the accident was your fault" when the police officer who was interviewed may not even have attended the scene of the accident, let alone witnessed the event. Many people would think that their case was unmeritorious and give up when in fact the police officer "opinions" would be inadmissible in a court. Similarly, a report from a forensic accountant may appear insurmountable when faced with a cost of thousands of dollars to obtain a report in reply, assuming the injured person was even aware of the possibility of answering such material.

12. A clear culture has developed in claims handling whereby insurers routinely deploy their access to experts, police and the medical profession to defeat a claim. Rather than an exchange of information as promised, what has arisen is a quasi-forensic approach fueled by an adversarial approach where in the vast majority of cases only the insurer is properly equipped and experienced. This imbalance has heightened the inequity of the scheme.

13. It can be anticipated that the regulator's position will be that at this stage the Scheme is not yet mature enough to determine whether it is meeting its objectives in terms of putting more premium dollars into the pockets of the seriously injured. There is however almost three years of data to draw on. The Association has endeavoured to understand how the Scheme is developing but despite its many attempts to obtain relevant information, the Association has not been given access to sufficient data to fully ascertain how claims, particularly claims for damages, are tracking compared with the actuarial assumptions which underpinned the original premium calculation of $551. The Ernst & Young (**EY**) *Quarterly Review as at 30 June 2020* was provided to the Association on 3 November 2020. It is a document which requires careful reading. The current figures for the operation of the Scheme which are included in this submission have been taken from that report, which is dated 13 August 2020. That this report was withheld until so close to the closing date for these submissions is consistent with a reluctance by SIRA to deal with stakeholders in an open way. The data it contains falls significantly short of what is necessary to understand how the Scheme is performing.

14. The actuarial assumptions underlying the *MAI Act* require examination. The pitifully low amount which has been paid out to date is the result of many factors, including:

    a. 60% of claims being closed after 26 weeks as minor injuries, where the Scheme actuary assumed a rate of 50%;

b. an over estimate of the number of disputes which would be determined in favour of the injured; and

c. a hugely reduced number of claims for damages due to the kind of insurer behaviour restricting the number of claimants who can access a claim for either continuing benefits or damages mentioned above.

15. The Government's objective of making premiums affordable has been met in the CTP Scheme. Any further changes should restore the balance between benefits and insurer profit in line with the stated objectives of the 2017 reforms.

16. On 14 October 2019 a request for data relevant to the CTP premium calculation was made by the Association under the *Government Information (Public Access) Act 2009* (NSW). The application was unsuccessful, and two reasons were given:

1. An asserted overriding public interest against disclosure; and

2. It was asserted that some of the data was not held by SIRA.

This is a publicly funded insurance Scheme. One of its stated objectives is "enhanced data collection and reporting, and real-time performance monitoring of insurer behaviour and claims experience, to enable SIRA to better regulate the scheme".[1] The reasons for refusing to make the data available were inconsistent with the spirit of the legislation. SIRA was given the power to collect and regularly publish a range of insurer profit, filing and loss ratio information. That information has been sought from SIRA and it has not been made available. Open consultation can only take place where there is open access to the necessary information.

17. The current CTP average premium in New South Wales is $486. The objective of reducing premiums has been met. In evaluating performance of the Scheme for the future, the focus should be upon delivering both the stated objectives and the legislative objectives relating to the payment of benefits under the Scheme, being:

a. To provide the fairest compensation regime possible consistent with maintaining the present premium;

b. To ensure that the majority of premium is paid to the injured with an emphasis on the most seriously injured;

c. To ensure that the restriction on claims for damages be confined only to injuries which are genuinely minor in nature without restricting or removing the right to claim damages for those with moderate or serious injuries;

d. To equip the regulator with sufficient resources to monitor insurer behaviour so that claims for statutory benefits are not rejected unreasonably and that unrepresented claimants are not discouraged from exercising their rights to claim compensation or damages because of that insurer behaviour. We note that currently 73% of claimants do not have legal

[1] New South Wales, *Parliamentary Debates*, Legislative Assembly, 9 March 2017 (Minister Dominello).

representation;

e. That CTP insurers, as receivers of public money that is compulsorily levied, should be required to act in all cases in a way which promotes the quick, cost effective and just resolution of disputes;

f. That the regulator in performing its statutory functions promotes genuine and open consultation for the purpose of the three-year review of the *MAI Act* and is equipped with sufficient resources to undertake a widespread consultation seeking feedback particularly from non-legally represented claimants who have left the Scheme.

18. The Association's submission addresses the following issues:

a. Scheme performance and claims for damages;

b. Data collection;

c. Role of the Regulator;

d. Legal costs;

e. Insurer behaviour;

f. Use of police opinion in liability decisions;

g. Minor injuries and Parliamentary scrutiny;

h. The Dispute Resolution Service; and

i. Future Action.

19. The Association considers that the Committee will not be able to properly perform its statutory function to review the Scheme without the information identified in this submission, including in section 10, and recommends that this information be urgently requested from SIRA and made publicly available.

2. Scheme Performance and Claims for Damages

20. The current focus on Scheme performance in the EY *Report for Claims up to June 2020* is on claims made in the first year of the Scheme.

21. There was a total of approximately 10,000 not at fault minor and non-minor injury claims: 6,118 minor and 3,794 non-minor.[2]

22. 60% of not at fault claims have been classified as minor.

23. Only around 1,500 non-minor claims involving treatment expenses remained active as at June 2020[3] and around 580 non-minor claims involving weekly payments.[4] In other words, over 75% of claims were "not active". Does this mean the files are closed?

24. How many common law claims can there be given those numbers? The fact that only 345 claims for damages had been made by June 2020[5] is staggering given that the three year limitation period will be expiring for these claims from 1 December 2020, and that this Scheme was meant to be much faster and more efficient than its predecessor.

25. The original assumption was that there would be 6,000 claims for damages each year.[6] It has now been revised down. The current estimate is either 4,400 or 3,685.[7]

26. How can those figures have any credibility when there are only somewhere between 1,500 and 2,100 active claims?

27. Another factor which must operate to reduce the anticipated number of damages claims is the confinement of damages for non-minor injuries under 10% Whole Person Impairment (**WPI**) to economic loss. A significant proportion of those claimants will have no entitlement to damages because they were not and will not earn income in the future irrespective of the accident. Less than 600 of those claims from the first year have ongoing weekly payments. This is telling, and demonstrates that the number of common law claims will be much lower than assumed.

28. The statutory benefits scheme appears to be stable. Treatment expenses are around $30 million per quarter.[8] Weekly payments are not growing.[9]

29. The honeymoon period would appear to be over.

30. Based on the most recent data, 60% of not at fault claims are assessed as minor. The effect on delivery of benefits to the most seriously injured of capturing too many claims as minor is profound. The shift from a 50% to a 60% minor injury classification has this effect:

---

[2] EY, June 2020, 17-18.
[3] Ibid, 43.
[4] Ibid, 43.
[5] Ibid, 20.
[6] EY, *Cost Regulation Costing*, 6 July 2017, 9.
[7] EY, July 2020, 12 and 20.
[8] SIRA Open Data.
[9] Ibid.

1. 1,000 minor injury claims at $5,900 each = $5 900 000 [$5.9 million], as opposed to
2. 1,000 non-minor injuries at 100K = $100 000 000 [$100 million]; or
3. 1,000 non-minor injuries at $500K if over 10% WPI = $500 million.

31. The contrast is staggering. Of course the reality is that those non-minor claims would be a combination of above and below the 10% WPI threshold, and so their value would be somewhere in the middle. The insurer retains the difference. On any account, this represents an extraordinary sum.

32. The minor injury test is not fair, and it is not easy to apply. The Association has previously advocated for a 5% WPI test for minor/non-minor injury. A recommendation from this Committee for amendment of the minor injury test to "at least 5% WPI" would assist in removing one of the greatest injustices in this scheme.

3. Data Collection

33. The CTP Open Data page on the SIRA website records gross amounts paid under the Scheme to date. There is no doubt that premium and claims numbers are well within Scheme design objectives. To determine whether the Scheme is meeting its objectives in relation to those injured in motor accidents, it is necessary to genuinely understand what has happened with the 32,000 claims which have been made to date.

34. The following information, which could be readily gleaned from data presently collected by SIRA, would give an excellent insight into how the Scheme is operating:

    a. How many current claims for statutory benefits are open on each CTP insurers' books;

    b. How many current open files include a concession or determination that an injured person has exceeded the 10% whole person impairment threshold;

    c. How many current and open claims for damages does each insurer have;

    d. How many current claims involve ongoing weekly benefits in the statutory benefits Scheme.

35. This is data which SIRA no doubt has and which should be made available immediately so as to put the overall figures into context and permit an understanding of whether claim numbers are escalating or whether they have stabilised.

36. The SIRA website states that there have been approximately 10,000 internal reviews out of around 32,000 claims (on average one in three) in relation to disputes undertaken by insurers and that there have been over 5,000 disputes. Again, further details about the current number of disputes would put those large numbers into context. This is a high number of disputes and we have no further information concerning them, or their outcome.

37. It is not sufficient for broad cumulative figures to be provided without the detail essential for a proper understanding of the Scheme's operation. The public are entitled to know how the Scheme is working and all reasonable efforts must be made to identify how the Scheme is operating now, at the conclusion of the three year "honeymoon period", a statutorily recognised (hence this review) point at which it was considered reliable assessment of the Scheme's performance would be possible. That the Scheme numbers suggest fewer claims than the modelling predicted can no longer be explained on the basis of the honeymoon period: three years was considered to be the time at which Scheme performance would be sufficiently indicative to justify formal review.

38. Despite its best efforts the Association has not been able to obtain any elucidation of this detail.

39. The premium assumption made in 2017 was that $129 premium dollars or 23.4% of the $551 premium would be paid as damages per annum. With 5.8 million registered vehicles in New South Wales, approximately $750 million of annual premiums was notionally allocated to damages claims when designing the scheme in respect of damages paid by 1 December 2020, a total of $2.25 billion over the three years from 2017-2020.

40. At this point total payments for modified common law claims are $54 million in 2019-20. The amount paid out in damages is less than 2.5% of the amount that the Scheme was designed to pay out for these claims over the last three years. Limitation periods are fast approaching: the shortfall in payments will be "baked in" every day after 1 December 2020.

41. The objective of putting a greater proportion of benefits into the pockets of the seriously injured has not been achieved.

42. The Schedule 1E assumption for the average not at fault claim, where WPI is greater than 10%, was $494,000. The assumed cost of such a claim is now recently estimated at $504,000. If that assumption has been borne out, there have been around 100 common law claims paid out under the Scheme to date. The regulator will know how many claims have been paid out to date. If injured persons' access to a claim for damages is working in accordance with the original design of the *MAI Act*, there should be thousands of claims for damages on foot by this stage. In practice such a claim is generally made between one and two years after an accident. There is no other rational or logical reason why so few claims would have been made, other than that the insurers have too much control over the process and are conducting themselves in a way which deters legitimate claimants from enforcing their rights.

43. SIRA and the CTP Insurers may seek to draw a comparison with a slow uptake in claims following the introduction of the *Motor Accidents Compensation Act 1999* (NSW) (***MACA***) in relation to damages claims. That is not a proper analogy. The *MACA* saw the introduction for the first time of the 10% WPI threshold which took some time for the legal profession to understand. The approach to a claim for damages under the *MAI Act* in terms of the threshold is identical to the *MACA* and so there has been no similar barrier to proceeding with a claim notwithstanding the change in the legislation. If damages claims are down significantly, which they appear to be, there must be some other explanation. The obvious factors include:

    a. A definition of minor injury which captures more serious injuries thereby removing the right to claim damages;

    b. The deliberate removal of the legal profession from the process;

    c. The imbalance of power in favour of the insurers; and

    d. The lack of knowledge on the part of self-represented claimants regarding their legal rights and the value of their claims.

44. It would greatly assist in the review of the Scheme if the Committee could identify with the assistance of the regulator the position in relation to the number of claims for damages that have been made to date and the number of claimants who have achieved the greater than 10% WPI threshold. There will also be available data on the size of awards for non-economic loss and economic loss damages.

45. The assumptions underlying the original premium calculation were recorded in the original publication of the 2017 Motor Accident Guidelines at Schedule 1E. These have subsequently been updated without recording the original assumptions and so it is necessary to go back to the

historical documents to identify whether, and to what extent, any of the assumptions have changed over time. There have been some significant changes. For example, the average claims size of a not at fault minor injury was originally assumed to be $12,700 as at 1 December 2017. By 15 January 2020, that figure had reduced to $5,900. The current claims data records that there have been 8,094 claims assessed as minor injury.

46. The total payments to date for treatment and care are $260 million. The original costing was $323 million per year for these payments in the mature scheme. The Scheme actuary predicted that 56% of these payments would be made in Year 1 and 68% by the end of year 2.

47. The total payments for treatment and care in the past 12 months have been $112 million. That is for 2.8 accident years. If you ignore year 1, there should be payments for 56% of $323 million for two years and 68% of $323 million for one year, a total figure of $400 million. Again, the reality falls far short of the Scheme design.

48. The overall figures show that still now barely 5% of premium dollars are making their way into the pockets of the injured.

4. Role of the Regulator

49. The Association is concerned with the role the regulator plays in the process of understanding the operation of the scheme.

50. As the substantive submissions above demonstrate, data is crucial to understanding the way in which the Scheme is performing. SIRA purports to consult with stakeholders including the Association and conducts forums, the ostensible purpose of which is to provide information to Stakeholders. Information is presented in pre-packaged form which, from the perspective of the Association's representatives, paints an inconsistent and impenetrable picture.

51. In particular, there is an apparent reluctance to recognise that different assumptions are being used now than those which informed Scheme design. The shifting assumptions regularly present a state of affairs which precludes ready comparison with how the Scheme designers said the Scheme would work.

52. SIRA has demonstrated a consistent reluctance to advance the position on matters of the provision of data and the identification of the changing assumptions. This has become a considerable concern.

53. SIRA's role is defined by section 23 of the *State Insurance and Care Governance Act 2015* (NSW). The relevant objects under that section are:

> (a) to promote the efficiency and viability of the insurance and compensation schemes established under the workers compensation and motor accidents legislation and the *Home Building Act 1989* and the other Acts under which SIRA exercises functions,
>
> (b) to minimise the cost to the community of workplace injuries and injuries arising from motor accidents and to minimise the risks associated with such injuries,
>
> …
>
> (d) to ensure that persons injured in the workplace or in motor accidents have access to treatment that will assist with their recovery,
>
> (e) to provide for the effective supervision of claims handling and disputes under the workers compensation and motor accidents legislation and the *Home Building Act 1989*,
>
> (f) to promote compliance with the workers compensation and motor accidents legislation and the *Home Building Act 1989*.

54. The Association considers that SIRA is failing to pursue the object of efficiency in the CTP Scheme, ensuring access to treatment and promotion of compliance with the *MAI Act*.

55. SIRA's statutory role as an independent regulator includes prudent stakeholder scrutiny of scheme performance. However, on all but a few occasions, requests for data made by the Association to SIRA have been rejected, the reasons given have been confidentiality or difficulty in obtaining the information. Occasionally we have not received a reply. Never has SIRA said that a piece of information sought by the Association is irrelevant or liable to be misunderstood. The Association

is concerned that not releasing relevant data, which is in the public interest to scrutinise the Scheme's operation, is contrary to the objects of the legislation which in turn impacts on public confidence in the regulator's ability to effectively perform its statutory mandate.

56. Where confidentiality is cited as the reason for not providing the data the Association has suggested anonymisation of data, however no response has been forthcoming.

57. Unless a request can be dismissed as frivolous, irrelevant or misconceived, SIRA as regulator should be investigating to ascertain whether the requested data does shed light on scheme operation. Rather, it obfuscates and delays, at best, and refuses or does not respond, at worst.

58. The Association suggests that legitimate requests for data on the operation of the Scheme should be dealt with by SIRA and if there is any commercial or other sensitivity the raw data may be provided in a de-identified format or under a commercial-in-confidence obligation.

59. Second, as outlined below, specific examples of improper claims handling have been supplied by the Association to SIRA for the purpose of investigating the prevalence and basis for them.

60. A particular concern is the use by insurers of police officer statements to "persuade" claimants as to their being "mostly at fault" with serious consequences for their entitlements. A practice has developed whereby insurers notify claimants of having formed the view that a claimant is mostly at fault by reference to observations made by police officers without them having attended the scene of an accident.

61. When raised with SIRA the response has been to seek to address the issue on a claim by claim basis rather than to look into or acknowledge what appears to be a systemic issue. In that way the offending practice and its underlying approach are not addressed and the result is that only the very few claims that ever come to a lawyer receive any type of action directed to insurer conduct.

62. It should never be the role of the regulator to deal with individual claims: its role is to regulate in accordance with the objects under which it was created. That involves dealing with requests for data in a way which promotes those objects: providing it to stakeholders is likely to assist, whereas denying it places the insurers beyond scrutiny and frustrates stakeholder input on the issues of scheme efficiency and outcome delivery, two primary objects for SIRA.

63. The approach which should be taken involves identifying undesirable trends in claims handling at the earliest possible opportunity before it becomes the norm.

5. Legal Costs

64. The public should be able to have confidence that state agencies and the schemes administering motor accidents injury compensation are accessible and transparent, and will afford the injured a fair opportunity to uphold their lawful rights. Unfortunately, the reality is very different. The system is failing to care for or adequately support the injured, with the effect of leaving the injured to fend for themselves against insurance companies and Scheme agents who have access to lawyers experienced in the areas in question. The legislation is extraordinarily complex, involving cross references to other pieces of legislation, regulations, claims and medical guidelines.

65. The Scheme has become increasingly technical, unnecessarily bureaucratic and difficult to navigate without legal assistance. The public are not informed of their rights, including the right to seek legal advice. In fact, victims are actively encouraged to seek to resolve the matter themselves, resulting in increased stress and emotional strain, which frequently results in an unfair outcome.

66. A common denominator in the failure of both the workers compensation and motor accident schemes to produce fair results for claimants is directly linked to the restrictions placed on access to legal advice in these schemes. Lawyers bear witness to the system's operation and inequity. Yet, when the legal profession has sought to raise the alarm over the way the injured are being treated, our concerns have been maligned and misconstrued by governments and departments as self-interested or venal. The legal profession owes its paramount ethical and legal duty to the administration of justice. This means the Association has a duty to speak out on behalf of the vulnerable members of our community left to wrestle with a system that, on the available evidence, favours insurers, not the injured.

67. In almost three years, legal costs for claimants total $6 million, compared with $24 million for insurers' legal costs and investigations. There is no true comparison because insurers can afford to employ counsel. That is a sad reflection of the role of the legal profession in this Scheme because lawyers have been effectively cut out of this process. People have been told they don't need a lawyer. Approximately $1,600 is payable to a lawyer for a minor injury dispute which can involve several times that amount of work. Recourse to litigated claims, and an occasional exceptional costs order, are of no use to claimants in the day to day operation of this Scheme.

68. The principal reason that the available costs are so low is again due to the inflated assumptions made in July 2017 concerning the number of disputes which would involve lawyers in the statutory benefits scheme. It was assumed that there would be 12,000 disputed claims per annum, with each claim having multiple disputes.[10] That produced an allocation of $130 million for legal costs in the statutory scheme per annum.[11]

69. To date there have been 5,549 disputes in the Dispute Resolution Service (**DRS**) with total legal costs of $6 million in almost three years.[12] The approach to legal costs needs to be addressed as a matter of urgency in order to address the imbalance between injured motorists and CTP insurers.

[10] EY *Cost Regulation Costing*, 6 July 2017, 8.
[11] Ibid, 23.
[12] SIRA Open Data.

This is an example of a mistake which should be recognised and rectified.

70. The $50 000.00 and $75 000.00 no contracting out provisions are also operating perversely. It is possible for a lawyer to provide a service, which after disbursements can mean that most professional fees are written off. These limitations are unsustainable.

71. It was not presented that way in July 2017 when SIRA modelling suggested that there would be $130 million in non-contracted out legal costs in the statutory scheme per annum, and $258 million in common law costs per annum. There is obviously scope for increasing scale fees for legal services to a realistic level, which would benefit the operation of the Scheme by providing injured persons with recourse to proper legal advice, as opposed to the current situation where the scale costs in the statutory Scheme are unrealistically low, to the point that it is not viable to provide legal services in many cases.

72. That legal costs in the statutory Scheme are 4.6% of the annual assumption suggests that the Scheme is not working as intended.

73. The paucity of legal costs in the statutory Scheme has a malignant influence on the Scheme's performance: overwhelmingly people coming into the Scheme are generally not legally represented. The Scheme is presented, including on SIRA's website, as one not requiring a lawyer, notwithstanding that, on any view, the Scheme represents one of the most complex legislative regimes ever enacted, perhaps only bettered by the complexities of the *Income Tax Assessment Act 1936* (Cth).

74. As a result, most decisions, some of them determinative of wider rights such as the entitlement to damages, are made in the absence of a claimant having legal advice. In most cases no lawyer protecting the claimant's interests will ever see these decisions. Claimants then leave the Scheme, assuming they have been paid all of their entitlements and dealt with fairly. If they have been dealt with fairly, it must follow from these figures that the Scheme is not performing as intended. If they have not been dealt with fairly, the whole justification for the Scheme (a new era of insurer behaviour) is absent and it is not performing as intended.

6. Insurer behaviour

75. The *MAI Act* was meant to herald a new world of insurer behaviour. This has not occurred. Insurers are using all traditional means to reject claims. Of the 31,439 claims lodged since 1 December 2017 there have been 10,066 insurer internal reviews which have resulted in 5,306 disputes. On average one in three claims has been the subject of a dispute with an insurer. That does not take into account those claimants who will have accepted an insurer's decision without seeking internal review.

76. The Association has previously submitted in the workers compensation context and in relation to the *MAI Act* that requiring an injured person to carry a dispute from an adverse insurer's decision to adverse internal review to a hearing in the DRS is oppressive. The system is not quick or just in that regard. The Association stands by those submissions.

77. Insurers have spent $24 million investigating claims. This figure includes the cost of factual investigation, surveillance and actuarial and accounting reports. That sum is in addition to the insurer's receiving a proportion of every CTP premium for the costs of administering each claim file. The fact that the average claim size for a not at fault statutory claim is half what was expected is in significant measure due to insurers successfully defeating claims at an early stage, particularly against those without legal representation.

7. Use of Police Opinion in Liability Decisions

78. It is common for private investigators retained by CTP insurers to interview police officers when investigating liability disputes, part of which is recorded and takes place at a police station. That interview is then relied upon by an insurer when giving written notification to a claimant that their claim has been unsuccessful. The relevant liability notice will tell the injured person that the police consider them to be at fault for the accident.

79. A particular concern is the use by insurers of police officer statements to "persuade" claimants as to their being "mostly at fault" with serious consequences for their entitlements. A practice has developed whereby insurers notify claimants of having formed the view that a claimant is mostly at fault by reference to observations made by police officers attending the scene of an accident.

80. The officers were not present at the accident scene when the accident happened. They are not experts in any discipline relevant to accident reconstruction or injury causation: they are general duties police. They are spoken to by an investigator.

81. The claimant – with no legal representation in nearly all cases – is told by the insurer "the police have been spoken to and they think you were speeding", or similar. The average person, with no knowledge of the laws of evidence, and assuming a reputable licensed insurer would not rely on such a statement unless such an opinion were admissible in court, will be strongly deterred from pursuing a claim confronted with this statement. The true position is, of course, that the opinion is likely, almost always, to be inadmissible.

82. For example, an elderly woman was parking her car in a suburban carpark when another vehicle

ran into the back of her. In the aftermath her vehicle travelled 50 or 60 metres before colliding with a tree. She was severely injured. There was significant damage to the rear of her motor vehicle. The liability notice issued by the insurer included the following:

> "Police also confirmed that they considered these as two separate motor accidents and have held you to be responsible for the motor accident".

83. That liability notice was issued even though the driver of the other vehicle had refused to provide a statement to the insurance company's investigator. The insurer did not inform the woman or her family of that fact, rather it relied on the assertion of a police opinion as to liability without proper disclosures of lack of expertise or jurisdiction for the police to so determine, and in a manner that relies on the statement and purported police authority to dissuade injured from pursuing appropriate claims. It is not an isolated event.

84. There is a similar problem with the use of accident reconstruction experts and accountants retained by insurers to refute aspects of claims. The average claimant would not know where to begin to obtain contradictory material and the scheme is structured so that they are not likely to find out.

85. When raised with SIRA, the response has been that it will only take an interest in our complaints about these type of issues if the names of the claimants are disclosed to it.

86. The result is that only the very few claims that ever come to a lawyer receive any type of action directed to the improper behaviour of the insurer.

87. It is submitted that the Committee should explore the use of police opinion in liability disputes with the CTP insurers.

88. The motivation for an insurer in defeating such a claim is obvious. This particular woman has lost her independence and is now living with her children who have to fund home modifications and provide care for their mother. Her ongoing needs, and her ongoing disabilities have not been compensated. She has legal representation, and so a remedy will be pursued, but that is not the point. This was meant to be a system which operates fairly for all injured motorists. 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. It is not meant to be a Scheme for the unjust enrichment of insurance companies.

89. Fraud is not a factor in these liability disputes.

90. The Committee should recommend that insurers be required to excise completely the use of police opinion in liability notices.

8. Minor Injury and Parliamentary Scrutiny

91. The Association has made submissions, including to the New South Wales Parliamentary Regulation Committee's inquiry into the making of delegated legislation, concerning the use of Henry VIII clauses to permit legislative change without debate in Parliament.[13] These concerns were acknowledged in the Regulation Committee's final report, published on 22 October,[14] which recommended that the Attorney General refer to the NSW Law Reform Commission terms of reference including:[15]

    a. The extent and use of delegated legislative powers in New South Wales; and

    b. the need for additional safeguards in relation to the use of Henry VIII provisions.

92. Section 1.6(4) of the *MAI Act* provides for the Regulations to amend the definition to either include or exclude specified injuries from the definition of minor injury. It is submitted that such a course which will affect the rights of individuals, inevitably including the removal of rights for either individuals or insurers, should not be undertaken by amending the Regulations.

9. The Dispute Resolution Service

93. The Association suggests that the Parliamentary Committee should enquire into the operation of the DRS in relation to:

    a. decisions concerning persons lacking legal capacity, and

    b. the approval of common law settlements for claimants without legal representation.

94. There is presently a lack of transparency in relation to these decisions are a result of the limited publication of decisions by SIRA.

10. Future Action

95. The three-year review of the *MAI Act* is an opportunity to reflect upon the operation of the Scheme, with the benefit of comprehensive data on its operation. There are shortcomings and they need to be recognised. This will only be achieved through an open and impartial consultation process. The Association is committed to maintaining its engagement with SIRA in that process. It is apparent that the Scheme is not meeting its objectives. At present the greatest beneficiaries from the *MAI Act* are the CTP insurers. It would be to their benefit to extend the honeymoon period indefinitely. That should not be permitted.

96. In order to obtain a full understanding of the current operation of the Scheme the following data is necessary. It will all be readily available. The Association has sought this information from

[13] See NSW Bar Association, *Submission No 8* (2020) pages 7-9 <https://nswbar.asn.au/uploads/pdf-documents/submissions/0008_New_South_Wales_Bar_Association_Regulation_inquiry.pdf>.

[14] NSW Legislative Council Regulation Committee, *Making of delegated legislation in New South Wales*, Report 7, October 2020, 28-29.

[15] Ibid, recommendation 2.

SIRA but it has not been provided. It is submitted that the Committee will not be able to properly perform its statutory function to review the scheme without the following information:

1. In relation to the Schedule 1E assumptions a breakdown is required between the different components (ie weekly statutory payments, care and treatment, common law economic loss, common law non economic loss), for each of the following:
    a. Average Claim Size – At Fault claims;
    b. Average Claim Size - Not at Fault Minor Injuries claims;
    c. Average Claim Size - Not at Fault Claims WPI greater than 10%;
    d. Average Claim Size - Not at Fault Claims WPI with less than or equal 10%;
2. The data for both the month of the accident month as well as the month the claim was lodged (i.e. for accidents that occurred in December 2017 the number of claims lodged in December 2017, January 2018, February 2018 etc.);
3. For each accident month, the number of claims classified as:
    a. At fault claims, not at fault claims and not yet determined claims;
    b. At fault claims or mostly at fault claims or not at fault claims involving minor injury;
    c. Not at fault claims involving non-minor injury;
    d. Not at fault claims involving non-minor injury, with less than or equal to 10% WPI;
    e. Not at fault claims involving non-minor injury, with greater than 10% WPI; and
    f. Compensation to relatives' claims;
4. For each accident month the number of claims that were classified initially as a not at fault minor injury then had this assessment subsequently overturned to non-minor injury. In this respect information regarding the date of the accident and when the month of the initial assessment was made and when this decision was overturned should be provided;
5. For each accident month, a monthly running accumulated total of payments made by the insurer for:
    a. All accidents;
    b. Weekly statutory payments;
    c. Care and treatment;
    d. All non statutory payments;

e. Common law damages;

f. Payments associated with at fault claims and not at fault minor injury claims;

g. Not at fault accidents with non-minor injuries claims; and

h. Compensation to relative claims;

6. The weekly statutory benefit payments for the last week of the years ended 30 June 2018, 2018 and 2020 and the number of individuals to which these payments related;

7. For each accident month:

a. The number of claims that have been settled;

b. The number of claims that are expected to be settled through common law claims;

8. The average lag time between the date of the accident and the date of the common law damages payments. In this respect information should be provided for each common law claim regarding:

a. The date when the common law claim is recorded;

b. The date of the accident;

c. The legal costs;

d. Details of any delays associated with the COVID-19 pandemic;

e. Whether the WPI was less than or equal to 10%; and

f. Whether the WPI % was greater than 10%;

9. In respect of each litigated matter:

a. The date when the litigation is recorded;

b. The date of the accident;

c. The legal costs;

d. Details of any delays associated with the COVID-19 pandemic;

e. Whether the WPI was less than or equal to 10%; and

f. Whether the WPI % was greater than 10%;

10. A copy should be provided of the:

a. Universal claims data (UCD) tier 1 and 2 motor vehicle accident as at 30 September 2020; and

b. Insurer premium returns as at 30 June 2020;

11. Since the commencement of the scheme, the number of workers compensation claims that have subsequently claimed damages and / or ongoing care under the *MAI Act*;

12. Details of:

    a. The month of the accident;

    b. The date of commencement of the *MAI Act* payments for each accident;

    c. A breakdown of the amount paid for each accident;

13. Details of each compensation to relatives claim including:

    a. The month of the accident,

    b. The legal costs per claim;

    c. Damages awarded.

11. Conclusion

97. Crisis intervention has become the method of choice for the systemic removal of rights in workers compensation and motor accident claims in NSW.

98. It is a feature of the Scheme that the general public know little of it unless and until they have an injury: they have no particular interest in the scheme until then. By contrast, insurers have a direct interest from the beginning of any discussion of reform and have the resources to amass actuarial, accounting and medical arguments without fear of being contradicted by the uninjured public.

99. The Scheme should be designed to provide the injured with the support that they need, with a minimum of bureaucratic complication.

100. It is unacceptable to expect an injured person to wage a lengthy campaign against an insurance company to obtain what is their legal right. The growth in bureaucracy associated with claims is astonishing and is a sure sign that the scheme is not designed for, or to assist, the injured.

101. Thank you again for the opportunity to make a submission concerning this important issue.

2

Supplementary Submission No 8a

INQUIRY INTO 2020 REVIEW OF THE COMPULSORY THIRD PARTY INSURANCE SCHEME

Organisation: New South Wales Bar Association

Date Received: 10 December 2020

NEW SOUTH WALES
BAR ASSOCIATION

Our ref: 20/12

Mr Wes Fang
Chair, Standing Committee on Law and Justice
Review of the Compulsory Third Party Insurance Scheme
Legislative Council
Parliament of New South Wales

10 December 2020

By email

Dear Chair

Supplementary submission to the Standing Committee on Law and Justice's 2020 Review of the Compulsory Third Party Insurance Scheme

1. Thank you for inviting a supplementary submission concerning the operation of the *Motor Accident Injuries Act 2017* (NSW) (***MAI Act***) No Fault Statutory Scheme within the first 26 weeks of an accident.

2. The confinement of benefits to that period applies to those who are mostly at fault for an accident and those who have suffered a minor injury.

3. The finalisation of the entitlement to benefits in relation to determinations of minor injury is often made after the 26-week period has expired. To assist the Standing Committee, the Association has enclosed below examples of problems which have been encountered primarily by Claimants, who are mostly self-represented at the time, in relation to liability disputes and minor injury.

Liability Disputes

4. Examples of problems encountered in relation to liability disputes include:

    a. Delaying a decision on liability whilst investigations are undertaken;

    b. Making adverse decisions on liability on hearsay-based Police opinion which would be inadmissible in any Tribunal where the rules of procedural fairness apply;

    c. Relying on that type of Police opinion when the person responsible for the accident either has not or will not be interviewed for the purpose of the liability investigation;

    d. Relying on traffic reconstruction evidence to dispute liability for statutory benefits;

    e. Employing the approaches set out above in claims where there is a significant or even major injury requiring extensive ongoing medical treatment beyond 26 weeks;

    f. The most significant resources seem to be applied to claims in which a person has been seriously injured.

Minor Injury

5. The following are examples of problems encountered in relation to minor injury.

6. In many cases Insurers do not accept the opinion of a treating doctor, despite this having been promoted as a benefit of the Scheme in simplifying reducing disputes.

7. Claims officers and rehabilitation providers attend medical consultations between a general practitioner and a claimant. This appears to be creating problems with the doctor patient relationship, including undermining doctor patient privilege.

8. There have been instances of inappropriate behaviour by claims officers or rehabilitation providers in attending medical examinations. Examples of such behaviour include debating a person's capacity for work during the consultation with the doctor and informing a Claimant in that context that their claim was going to be closed because surveillance material had been obtained.

9. It is common for an Insurer to refuse to fund CT or MRI scans in relation to soft tissue injuries of the neck or back but to then obtain medico-legal reports from radiologists, orthopaedic surgeons or neurologists for the purpose of arguing that a person's injuries reveal pre-existing degenerative change unrelated to the subject accident when at law such an aggravation is causally related to the accident.

10. The Insurers proceed on guidelines which require a direct connection between a motor accident and an injury. This seems to be interpreted as requiring the nature and extent of the injury to be apparent at the time of the impact and reported immediately. This approach is very unfair when there are many valid reasons why such reporting may not be able to be made at that stage, and it does not reflect the relevant legal test.

11. Correspondence from Insurers is overly detailed. It often contains lengthy information which is irrelevant to the subject of the correspondence. There is no clear or consistent template for providing the necessary information for unrepresented Claimants in protecting their own interests in a dispute with an insurance company.

12. The Association is also concerned that claims officers are not informing the injured about their entitlement to care. In some cases, Claimants have been told that they can no longer make such a claim when an enquiry has been made about obtaining help with housework.

13. The process of an Insurer determining minor injury in effect determines many injured Claimants' legal rights once and for all. Claimants are being forced to engage directly with insurance companies in the earlier stages of their injury when they are at their most vulnerable. The Association is concerned that this is a significant factor in Claimants abandoning their claims.

14. For those Claimants who have successfully established that they are not most at fault in those claims where there is a liability dispute, those people are then confronted with all of the disputes that can arise in relation to benefits in the first 26 weeks.

15. The use of accounting and forensic reports to assist in determining the appropriate rate or entitlement to weekly payments causes unnecessary delay and significant stress to Claimants and also creates a completely one sided controversy.

16. A major failing in the Scheme in relation to minor injury is the fact that an Insurer's determination of minor injury is binding for the purpose of a claim for damages. In other

words, no claim for damages can be brought. What in effect is happening is that for those who have been found to have suffered minor injury, their rights are determined, usually shortly after the 26-week period has expired, before they have even had the opportunity of properly understanding what is going on. Their rights are being removed in circumstances where Insurers have an unfair advantage. This problem arises as a result of the operation of section 4.4 of the *MAI Act* which provides that no damages may be awarded to an injured person if the person's only injuries resulting from the motor accident were minor injuries.

17. The legislature saw fit to provide that statutory benefits determinations relating to fault, contributory negligence or any other such matter prescribed by the regulations is not binding in connection with a claim for damages (see section 3.44 of the *MAI Act*).

18. The amendment of the *MAI Act* to make a decision as to minor injury non-binding would remove the current incentive for Insurers to take whatever steps they can to succeed in obtaining a finding of minor injury at an early stage. That would go a long way towards levelling the playing field for injured Claimants and restore a degree of fairness to the system.

Conclusion

19. If the Association can further assist the Standing Committee, please contact our Director of Policy and Public Affairs, Elizabeth Pearson, at first instance via .

Yours sincerely

Michael McHugh SC
President

NEW SOUTH WALES
BAR ASSOCIATION

3

Our ref: 21/289

30 August 2021

The Hon. Wes Fang, MLC
Chair, Standing Committee on Law and Justice
Parliament House
Macquarie Street
SYDNEY NSW 2000

By email: *law@parliament.nsw.gov.au*

Dear Chair

Report No 77: 2020 Review of the Compulsory Third Party Insurance Scheme – Clarification on Recommendation One

I write on behalf of the New South Wales Bar Association (**the Association**) in relation to *Report No 77: 2020 Review of the Compulsory Third Party Insurance Scheme* (**Report**), which was handed down by the Standing Committee on Law and Justice on 30 July 2021.

Firstly, the Association again thanks the Standing Committee for the opportunity to contribute to the review. The Report is a significant body of work and will undoubtedly be of assistance during the independent statutory review of the *Motor Accident Injuries Act 2017* this year.

Having reviewed the Report, it seems that there is an inadvertent error in the second bullet point of Recommendation 1, which reads: "*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*".

Given the nature of the discussion on those matters in the body of the Report (eg, at paragraphs [2.8] to [2.22]), it appears that the second reference in the above sentence should instead be to "***non-minor***" injuries.

That is, if the intention of the recommendation is that the statutory review should consider how the 'minor injury' definition can be amended to avoid capturing those who do not have genuinely minor injuries (ie, those who have non-minor injuries), the Association respectfully submits that the second bullet point of Recommendation 1 should read:

> *That the current statutory review of the* Motor Accident Injuries Act 2017 *closely consider the following issues for reforms to the scheme:*
>
> …

> "*how the minor injury definition can be amended to ensure it does not ~~exclude~~ **include** those with genuine **non-**minor injuries, including in relation to psychological claims*".

The Association, and I am sure all other stakeholders, would greatly appreciate clarity on this issue.

Yours sincerely

Michael McHugh SC
President

4

LEGISLATIVE COUNCIL

STANDING COMMITTEE ON LAW AND JUSTICE

7 September 2021

D21/46640

Mr Michael McHugh SC
President
NSW Bar Association
Via:

Dear Mr McHugh

Thank you for your letter dated 30 August 2021, in which you request clarification on recommendation one from the 2020 Review of the Compulsory Third Party Insurance scheme. The committee has resolved that I respond to you and advise that the issues you have raised can be pursued at the time of the next review.

The committee appreciates your regular contribution to these reviews, and the detailed consideration your members give to matters relating to the scheme.

Yours sincerely

The Honourable Wes Fang, MLC
Committee Chair